IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF NORTH CAROLINA

CIVIL ACTION NO. 3:22-cv-00191

KANAUTICA ZAYRE-BROWN,)
)
Plaintiff,)
)
vs.)
)
THE NORTH CAROLINA)
DEPARTMENT OF PUBLIC)
SAFETY, ET AL.,)
)
Defendants.)

DEPOSITION OF

SARA BOYD, PH.D.

9:08 A.M.

FRIDAY, AUGUST 4, 2023

NORTH CAROLINA DEPARTMENT OF JUSTICE

114 WEST EDENTON STREET

RALEIGH, NORTH CAROLINA

CONTAINS GENERAL CONFIDENTIAL INFORMATION

That's why I'm not a member of WPATH and have not been historically. However, in terms of the actual practice that you see most psychologists having to engage in, if a transgender comes into your office and they say, I need a letter, usually what they mean is, I'm in the process of getting the -- you know, contacted an agency or an organization. They've indicated, I need this letter so I'm coming to you to get a letter.

And so most of the time, what's happening is that the people who are actually going to be providing the medical care to them are operating under the WPATH standards of care and require two letters then from medical professionals. And so we had to -- that -- you know, that was the understanding and that's what you comply with. Whether you agreed with that provision or not, you knew that their medical care providers were going to require that.

Q. Okay. So I know that you don't endorse WPATH. I'll get to that in a moment. Did you say that most providers en- -- endorse it or follow it? I can't remember exactly what

you said.

A. I would say that most of the medical care providers that I -- that I've worked with are utilizing those standards in terms of how they determine somebody's appropriateness and what kind of hoops they should have to jump through before they can have --

Q. Uh-huh.

A. -- what they want. I would say that's -- it's an -- like an informal organizing kind of set of expectations for us as psychologists is that that's -- what we're going to do is what WPATH suggests we do in terms of providing letters and the requirements his- -- the historical requirements that the person have socially transitioned for a period of time before they're allowed to have those interventions and so forth. And so it was mostly that we ex- -- we believed that -- that the medical professionals were going to expect that of us in order to agree to do the procedures for the person or prescribe medication.

Q. Okay. Are -- do you have, like, a wholesale rejection of the WPATH standards or are there

specific parts of it that you disagree with?

A. The newer version that just came out, I think there are significant improvements there. My primary concern with WPATH is that it's predicated on a -- what I view as a binary-oriented medical essentialist model and I don't think there's an -- that WPATH has created enough room for nonbinary people or people whose gender may be not -- people who may not necessarily need or want surgical procedures or hormonal intervention. I also think that most of this treatment has to be highly individualized for the person. And I think WPATH describes themselves as these are flexible guidelines, you know, not a -- set in stone. But that's -- yeah, that would be my response to that question.

Q. Okay. So when it comes to the WPATH standard for, let's say, evaluating someone for -- evaluating someone and referring them for hormone therapy, what do you think of what WPATH says?

A. I think that most folks are able to make that decision. You know, my issue with it was that I didn't believe that somebody should

have to have transitioned socially for a period of time before they're permitted to access hormonal intervention or surgery.

Q. Uh-huh.

A. That's really my primary issue with it. I also don't think they should have to have so many letters from psychologists probably.

Q. Okay.

A. And that was my historical objection to WPATH was really more about the ways in which I felt that they actually prevented trans and gender-nonconforming folks from receiving care rather than facilitating it because my view is WPATH has a -- like I said, a narrow medical essentialist model historically, although I do see an improvement in the eighth version of the standards of care.

Q. Okay. So summing up, do you -- you think the -- the seventh standards are too restrictive with respect to you referring someone for gender-affirming care?

A. Yes. I think there were a number of people that were probably held back from receiving care that they needed because those standards were excessively restrictive.

there is a contribution that is coming from her own internal discomfort with continuing to have a phallus when that is not consistent with her gender identity. I do think that contributes to her gender dysphoria and it makes sense then rationally that coping with that is going to be a sensible step for her in terms of treatment.

Q. And to be clear, what do you mean by coping with that?

A. Well, I mean having -- having a procedure to -- you know, having bottom half surgery, whether that's a vulvoplasty or vaginoplasty, dealing with that component of it, of the internalized transphobia. And also, just the discomfort, emotional and psychological discomfort, with continuing to have a phallus, that is its own contribution. I think that's valid. I believe her when she says that.

Q. Do you have any reason to think that Mrs. Zayre-Brown can be cured of her gender dysphoria while she still has a penis or a phallus as she calls it?

A. Based on her statements, I think not. I

believe her self-report has consistently been that this is something that she sees as sort of a keystone intervention. I think the main difference really is just that in my view, she needs other things as well and that we want to be careful and mindful about the timing and the setting and the context of intervention to maximize the benefit that she's going to get so we can get as close to the benefit as she anticipates as we possibly can.

Q. Okay. You mentioned the -- the phrase necessary but not sufficient a little while ago.

Would you say that removing her phallus and having genital surgery would be necessary but not necessarily sufficient to cure her gender dysphoria?

A. Ultimately, yes. The question of the timing, I think, is a separate issue, but in the long-term sense, yes.

Q. Uh-huh. Did you find any contraindications for surgery?

A. So I can't speak to medical contraindications for surgery. And surgery, broadly speaking,

other components of whatever it is that they're dealing with because, like I said, most trans people, they have other things going on in their life that are -- you know, trauma in particular is so common that -- and -- and they're also at high risk in -- in carceral facilities. You know, PREA acknowledges that. So, you know, it's complicated and make -- does make it very difficult to answer these hypotheticals for that reason.

Q. Uh-huh. Okay. So I understand, and correct me if I'm wrong, but that in your view, undergoing surgery while she's in prison would be far from ideal for Kanautica.

Is that fair to say?

A. Yes, by her own account.

Q. Okay. If she were to undergo a vulvoplasty in prison, do you think it is likely or unlikely that she would receive psychological benefit?

A. I think it's likely she would get some degree of psychological benefit. I would definitely fall short of saying it would be curative or something close to curative because I think

there are a number of other factors. But would she get some psychological benefit from it? Provided that it went okay and she didn't have significant surgical complications, which is entirely possible and could cause all kinds of issues, then I think she would get some benefit from it. I think that's likely. I think even just finding out that she's going to get the surgery, whe- -- you know, in the community or elsewhere, I think that give -- also would give a benefit.

Q. Does it give the same benefit?

A. In the longer-term sense, likely, no. But in the short-term sense, probably, actually, there wouldn't -- I don't know that there would be that much difference. And, in fact, she might have more stability in terms of the benefit of having something scheduled because of the potential disruption that the medical process itself could cause for her.

Q. Okay.

MR. SIEGEL: Let's go off the record.

(Whereupon, there was a recess in the proceedings from 1:19 p.m. to 1:25 p.m.)

MR. SIEGEL: All right. We have no

EXHIBIT 2

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA

KANAUTICA ZAYRE-BROWN, *Plaintiff*, v. THE NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY, *et al.*, *Defendants*.	Civil Action No. 3:22-cv-00191

EXPERT REPORT OF DR. RANDI C. ETTNER, PH.D.

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I. INTRODUCTION

1. I am a clinical and forensic psychologist with expertise concerning the diagnosis and treatment of gender dysphoria. I am the past Secretary of, and I served as a member for more than 12 years on, the Board of Directors of the World Professional Association of Transgender Health ("WPATH"), the preeminent professional organization dedicated to the understanding and treatment of gender dysphoria worldwide. I have extensive experience treating transgender individuals with gender dysphoria in my clinical practice and have published numerous books and articles on the topic.

2. I have actual knowledge of the matters stated herein and could and would so testify if called as a witness.

3. I have been retained by counsel for Plaintiff Kanautica Zayre-Brown ("Mrs. Zayre-Brown" or "Plaintiff") to provide the Court with my expert evaluation and opinions regarding the appropriateness of the treatment for gender dysphoria provided to Mrs. Zayre-Brown by the Defendants. This report sets forth my opinions and conclusions, including (i) scientific information regarding gender dysphoria and its impact on the health and well-being of individuals living with gender dysphoria; (ii) information regarding best practices and the accepted standards of care for individuals with gender dysphoria; (iii) the results of my review of Mrs. Zayre-Brown's treatment for gender dysphoria and my in-person and telephonic interviews and assessment of Mrs. Zayre-Brown; (iv) the deficiencies in the justifications provided in the Division Transgender Accommodation Review Committee ("DTARC") case summary, dated February 17, 2022, regarding the denial of Mrs. Zayre-Brown's gender-affirming genital surgery (the "Zayre-Brown Case Summary" or "Case Summary," which was produced by Defendants in this case as DAC 3399-3403); (v) the deficiencies in the justifications for the conclusion in the DTARC Position Statement regarding Gender Reassignment Surgery dated March 23, 2022 (the "DTARC Position Statement" or "Position Statement," DAC 3404-3415) that gender-affirming surgery is never medically necessary; and (vi) certain of the erroneous statements, opinions, and conclusions made by Joseph Penn, MD and Sara Boyd, Ph.D., ABPP in their affidavits submitted in this matter, ECF No. 18-8, 18-6.

4. My conclusions and a summary of my opinions in this matter are set forth in Section XI (¶¶ 132-37) of this report, below.

II. QUALIFICATIONS

5. I am a licensed clinical and forensic psychologist with a specialization in the diagnosis, treatment, and management of gender dysphoric individuals. I received my Doctorate in Psychology (with honors) from Northwestern University in 1979. I am a Fellow and Diplomate in Clinical Evaluation of the American Board of Psychological Specialties, and a Fellow and Diplomate in Trauma/Post-Traumatic Stress Disorder.

6. During the course of my career, I have evaluated, diagnosed, and treated between 2,500 and 3,000 individuals with gender dysphoria and mental health issues related to gender variance from 1977 to present.

7. I have published four books related to the treatment of individuals with gender dysphoria, including the medical text entitled *Principles of Transgender Medicine and Surgery* (co-editors Monstrey & Eyler; Routledge 2007) and the 2nd edition (co-editors Monstrey & Coleman; Routledge 2016). In addition, I have authored numerous articles in peer-reviewed journals regarding the provision of healthcare to the transgender population.

8. I have served as a member of the University of Chicago Gender Board, am on the editorial boards of *Transgender Health* and the *International Journal of Transgender Health* and am an author of the WPATH Standards of Care for the *Health of Transsexual, Transgender and Gender-Nonconforming People* (7th version),

published in 2011. I am also an author of the newly released WPATH Standards of Care Version 8, published in 2022, and chaired the chapter on Institutionalized Persons. WPATH is an international association of 2,700 medical and mental health professionals worldwide specializing in the treatment of gender diverse people. I chair the WPATH Committee for Institutionalized Persons and provide training to medical professionals on healthcare for transgender prisoners.

9. I am on the Medical Staff at Weiss Memorial Hospital in Chicago, and I have lectured throughout North America, Europe, South America, and Asia on topics related to gender dysphoria and have given grand rounds on gender dysphoria at university hospitals. I am the honoree of the externally funded Randi and Fred Ettner Fellowship in Transgender Health at the University of Minnesota. I have been an invited guest at the National Institutes of Health to participate in developing a strategic research plan to advance the health of sexual and gender minorities, and in November 2017, I was invited to address the Director of the Office of Civil Rights of the United States Department of Health and Human Services regarding the medical treatment of gender dysphoria. I received a commendation from the United States House of Representatives on February 5, 2019, recognizing my work for WPATH and gender dysphoria in Illinois.

10. I have been a consultant to news media and have been interviewed as an expert on gender dysphoria for hundreds of television, radio, and print articles throughout the country.

11. I have been retained as an expert regarding gender dysphoria and the treatment of gender dysphoria in multiple court cases and administrative proceedings, including cases involving the treatment of individuals with gender dysphoria in prison settings. Over the past four years, I have given expert testimony at trial or by deposition in the following cases: *Diamond v. Ward*, No. 5:20-cv-00543 (M.D. Ga. 2022); *Stillwell v. Dwenger*, No. 1:21-cv-1452-JRS-MPB (S.D. Ind. 2022); *Letray v. Jefferson Cty.*, No. 20-cv-1194 (N.D.N.Y. 2022); *C.P. v. BCBSIL*, No. 3:20-cv-06145-RJB (W.D. Wash. 2022); *Kadel v. Folwell*, No. 1:19-cv-00272 (M.D.N.C. 2021); *Iglesias v. Connor*, No. 3:19-cv-00415-NJR (S.D. Ill. 2021); *Monroe v. Jeffreys*, No. 3:18-CV-00156-NJR (S.D. Ill. 2021); *Singer v. Univ. of Tennessee Health Sciences Ctr.*, No. 2:19-cv-02431-JPM-cgc (W.D. Tenn. 2021); *Morrow v. Tyson Fresh Meats, Inc.*, No. 6:20-cv-02033 (N.D. Iowa 2021); *Claire v. Fla. Dep't of Mgmt. Servs.*, No. 4:20-cv-00020-MW-MAF (N.D. Fla. 2020); *Williams v. Allegheny Cty.*, No. 2:17-cv-01556-MJH (W.D. Pa. 2020); *Gore v. Lee*, No. 3:19-CV-00328 (M.D. Tenn. 2020); *Eller v. Prince George's Cty. Pub. Schs.*, No. 8:18-cv-03649-TDC (D. Md. 2020); *Monroe v. Baldwin*, No. 18-CV-00156-NJR-MAB (S.D. Ill. 2020); *Gilbert v. Dell Technologies*, No. 19-cv-1938 (JGK) (S.D.N.Y. 2019); *Ray v. Acton*, No. 2:18-cv-00272 (S.D. Ohio 2019); *Soneeya v. Turco*, No. 07-12325-DPW (D. Mass. 2019); *Edmo v. Idaho Dep't of Corr.*, No. 1:17-CV-00151-BLW (D. Idaho 2018).

12. A true and correct copy of my Curriculum Vitae, which provides a complete overview of my education, training, and work experience and a full list of my publications, is attached hereto as **Appendix A**.

III. COMPENSATION

13. My clinical consulting fee in this case is $375.00 per hour for any clinical services, records review, or report drafting in connection with this case; $475.00 per hour for any depositions or oral testimony in this case, and $2,500.00 per day for any necessary travel in conjunction with this case. A true and correct copy of my engagement agreement in this case is attached hereto as **Appendix B**. As provided in that agreement, my compensation does not depend on the outcome of this case, the opinions I express, or the testimony I may provide.

IV. MATERIALS CONSIDERED

14. I have considered information from various sources in forming my opinions enumerated herein, in addition to drawing on my extensive clinical experience and my review of the literature related to gender dysphoria over the past three decades. Attached as **Appendix C** is a bibliography of relevant medical and scientific materials related to transgender people and gender dysphoria. I generally rely on these materials when I provide expert testimony, in addition to the documents specifically cited in particular sections of this report.

15. In preparing this report, I also reviewed and relied on Plaintiff's medical and mental health records, compiled by the North Carolina Department of Public Safety ("DPS"), which were provided to me by Plaintiff's counsel. Those that are referred to in this report are attached hereto as **Appendix D** ("App. D") through

Appendix E.[1] I also reviewed and relied on the Zayre-Brown Case Summary; the DTARC Position Statement; the complaint in this matter, ECF No. 1; the Affidavit of Joseph Penn, MD submitted in this matter, ECF No. 18-8 ("Penn Aff."); Dr. Penn's curriculum vitae, ECF No. 18-9; the Affidavit of Sara Boyd, Ph.D., ABPP also submitted in this matter ("Boyd Aff.), ECF No. 18-6; and Dr. Boyd's curriculum vitae, ECF No. 18-7, all of which were also provided to me by Plaintiff's counsel.

16. I also relied on an extensive in-person clinical interview and assessment I conducted of Mrs. Zayre-Brown, as well as a subsequent follow-up telephonic interview I conducted of Mrs. Zayre-Brown, my decades of clinical experience in the evaluation, diagnosis, and treatment of individuals suffering from gender dysphoria, and the relevant literature on these topics.

V. GENDER DYSPHORIA

17. The term "gender identity" is a well-established concept in medicine, referring to one's internal sense of oneself as belonging to a particular gender. All human beings develop this elemental internal conviction of belonging to a particular gender, such as male or female.

[1] Certain sensitive information in Mrs. Zayre-Brown's DPS medical records and included as appendices in this declaration has been redacted by Plaintiff's counsel. The categories of redacted information include Mrs. Zayre-Brown "deadname" (the typically masculine name given to her at birth and named utilized by DPS in their record keeping, despite Mrs. Zayre-Brown's legal name change in 2012) and sensitive health information, unrelated to Mrs. Zayre-Brown's gender dysphoria and need for gender-affirming surgery. Upon request, Plaintiff's counsel will readily provide the Court and Defendants' counsel with unredacted versions of these records, which Plaintiff's counsel obtained from Defendants.

18. At birth, infants are typically classified as male or female. This classification becomes the person's birth-assigned sex. Typically, persons born with the external physical characteristics associated with males psychologically identify as men, and persons born with the external physical characteristics associated with females psychologically identify as women. However, for transgender individuals, this is not the case. For transgender individuals, the sense of one's gender—one's gender identity—differs from the birth-assigned sex, giving rise to a sense of being "wrongly embodied."

19. For some, the incongruence between gender identity and assigned gender does not create clinically significant distress. However, for others, the incongruence results in gender dysphoria, a serious medical condition characterized by a clinically significant and persistent feeling of distress and discomfort with the gender they were identified as at birth (their "assigned gender" or "birth-assigned sex").

20. In 1980, the American Psychiatric Association ("APA") introduced the diagnosis Gender Identity Disorder ("GID") in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* ("DSM-III"). The GID diagnosis was maintained in a revised version of DSM, known as DSM-III-R (1987), as well as in DSM-IV which was issued in 1994.

21. In 2013, with the publication of the fifth edition of the DSM, the GID diagnosis was removed and replaced with a new diagnostic term: gender dysphoria. This new diagnostic term was based on significant changes in the understanding of

the condition of individuals whose birth-assigned sex differs from their gender identity. The change in nomenclature was intended to acknowledge that gender incongruence, in and of itself, does not constitute a mental disorder. Nor is an individual's identity disordered. Rather, the diagnosis is based on the distress or dysphoria that some transgender people experience because of the incongruence between birth-assigned sex and gender identity and the social problems that ensue. The fifth edition explained that the former GID diagnosis connoted "that the patient is 'disordered.'" American Psychiatric Association, "Gender Dysphoria," *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. 2013) ("DSM-5"). But, as the APA explained, "[i]t is important to note that gender nonconformity is not in itself a mental disorder. The critical element of Gender Dysphoria is the presence of clinically significant distress associated with the condition." *Id.* By "focus[ing] on dysphoria as the clinical problem, not identity per se," the change from GID to Gender Dysphoria destigmatizes the diagnosis. *Id.*

22. In addition, the categorization of gender dysphoria and its placement in the DSM system is different for gender dysphoria than it was for GID. In every version of the DSM prior to 2013, GIDs were a subclass of some broader classification, such as Disorders Usually First Evident in Infancy, Childhood, or Adolescence, or alongside other subclasses such as Developmental Disorders, Eating Disorders, and Tic Disorders. For the first time ever, DSM-5 categorizes the diagnosis separately from all other conditions. In the DSM-5, gender dysphoria is classified on its own. In 2018, the World Health Organization ("WHO") likewise reclassified the gender

incongruence diagnosis in the International Classification of Diseases-11. This is significant because the new classification removes gender incongruence from the chapter on mental and behavioral disorders, in recognition that it is not a mental illness.

23. The diagnostic criteria for Gender Dysphoria in Adolescents and Adults in DSM-5 are as follows:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).

2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated sex characteristics).

3. A strong desire for the primary and/or secondary sex characteristics of the other gender.

4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).

5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).

6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

24. In addition to renaming and reclassifying gender dysphoria, the medical research that supports the gender dysphoria diagnosis has evolved. Unlike DSM's treatment of GID, the DSM-5 includes a section entitled "Genetics and Physiology," which discusses the genetic and hormonal contributions to Gender Dysphoria. *See* DSM-5 at 457 ("For individuals with gender dysphoria . . . some genetic contribution is suggested by evidence for (weak) familiarity of transsexualism among nontwin siblings, increased concordance for transsexualism in monozygotic compared with dizygotic same-sex twins, and some degree of heritability of gender dysphoria[.]").

25. There is now scientific consensus that gender identity is biologically based and a significant body of scientific and medical research that gender dysphoria has a physiological and biological etiology (cause or origin). It has been demonstrated that transgender women, transgender men, non-transgender women, and non-transgender men have different brain compositions, with respect to the white matter of the brain, the cortex (central to behavior), and subcortical structures. *See, e.g.*, Rametti et al., 45 J. Psychiatric Res. 199 (2011); Rametti et al., 45 J. Psychiatric Res. 949 (2011); Luders et al. (2006); Krujiver et al. (2000). Differences between transgender and non-transgender individuals primarily involve the right hemisphere of the brain. The significance of the right hemisphere is important because that is the area that relates to attitudes about bodies in general, one's own body, and the link between the physical body and the psychological self.

26. In addition, scientific investigation has found a co-occurrence of gender dysphoria in families. Gomez-Gill et al. concluded that the probability of a sibling of

a transgender individual also being transgender was 5 times higher than someone in the general population. Gomez-Gil et al. (2010). And, in identical twins, there was a very high likelihood (33%) of both twins being transgender, even when reared apart, demonstrating the role of genetics in the development of gender dysphoria. *See* Diamond (2013) (abstract: "[t]he responses of our twins relative to their rearing along with our findings regarding some of their experiences during childhood and adolescence show their [gender] identity was much more influenced by their genetics than their rearing."); *see also* Green (2000).

27. It is now believed that gender dysphoria evolves as a result of the interaction of the developing brain and sex hormones. For example, one study found that:

> [d]uring the intrauterine period a testosterone surge masculinizes the fetal brain, whereas the absence of such a surge results in a feminine brain. As sexual differentiation of the brain takes place at a much later stage in the development than sexual differentiation of the genitals, these two processes can be influenced independently of each other. Sex differences in cognition, gender identity . . ., sexual orientation . . ., and the risks of developing neuropsychiatric disorders are programmed into our brain during early development. There is no evidence that one's postnatal social environment plays a crucial role in gender identity or sexual orientation.

Bao & Swaab (2011).

28. Similarly, Hare et al. found that "a decrease in testosterone levels in the brain during development might result in incomplete masculinization of the brain . . . resulting in a more feminized brain and a female gender identity." Hare et al. at 93, 96.

29. Efforts to change a person's gender identity are unethical, harmful, and futile. Researchers have documented the risks and harms of attempting to coerce individuals to conform to their birth-assigned sex. These include, but are not limited to, the onset or increase of depression, suicidality, substance abuse, loss of relationships, family estrangement, and a range of post-traumatic responses. *See* Byne (2016); Green, et al. (2020); Turban, et al. (2019). Numerous professional organizations have endorsed the Unites States Joint Statement Against Conversion Efforts, including the American Medical Association, The American Academy of Family Physicians, The American Psychological Association, The American Psychoanalytical Association, The World Professional Association for Transgender Health, and many other professional organizations. Several countries throughout the world, and states and municipalities in the Unites States, have enacted laws prohibiting health care professionals from engaging in conversion attempts.

VI. TREATMENT OF GENDER DYSPHORIA

A. WPATH Standards of Care

30. Gender dysphoria can be ameliorated or even effectively cured through medical treatment. The standards of care for treatment of gender dysphoria are currently set forth in the *World Professional Association for Transgender Health (WPATH) Standards of Care* (8th version, 2022). The WPATH promulgated Standards of Care ("SOC") are the internationally recognized guidelines for the treatment of persons with gender dysphoria and inform medical treatment throughout the world. The American Medical Association, the Endocrine Society, the

American Psychological Association, the American Psychiatric Association, the World Health Organization, the American Academy of Family Physicians, the American Public Health Association, the National Association of Social Workers, the American College of Obstetrics and Gynecology and the American Society of Plastic Surgeons all endorse treatment protocols in accordance with the SOC. *See, e.g.*, American Medical Association Resolution 122 (A-08) (2008); Hembree et al. (2009); American Psychological Association, *Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination* (2009) ("APA Policy Statement"). In addition, numerous courts have recognized the Standards of Care promulgated by WPATH as the authoritative standards of care for transgender individuals and concluded that there are no other competing, evidence-based standards that are accepted by any nationally or internally recognized medical professional groups.

31. Throughout this report, I make references to the 7th version of the SOC, with cites to that version referred to below in this report simply as "SOC." I refer primarily to that version because it is what was in effect until the 8th version of the Standards of Care was officially published by WPATH on September 15, 2022, and what was in effect during most of the period relevant to Mrs. Zayre-Brown's treatment by Defendants in this lawsuit. None of my opinions set forth below in this report that are based on the 7th version of the SOC are altered by what is in the 8th version.

32. As set out in the SOC, many transgender individuals with gender dysphoria undergo a medically indicated and supervised gender transition in order

to ameliorate the debilitation of gender dysphoria and live life consistent with their gender identity. The SOC recommend an individualized approach to gender transition, consisting of one or more of the following protocol components of evidence-based care for gender dysphoria:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
- Hormone therapy to feminize or masculinize the body;
- Surgery to change primary and/or secondary sex characteristics (e.g. breasts/chest, external and/or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support improving body image; or promoting resilience.

SOC at 9–10.

33. The treatment of incarcerated persons with gender dysphoria has been addressed in the SOC since 1998. As with protocols for the treatment of diabetes or other medical disorders, medical management of gender dysphoria for incarcerated individuals does not differ from protocols for non-institutionalized persons. Custodial status is not a medical justification to deviate from accepted standards of care or medically necessary treatment for any medical condition, including gender dysphoria. An individual's custodial status, housing status, and/or security classification are not *medical* justifications to deny medically necessary care, including surgical care, for the treatment of gender dysphoria or any other medical condition that I am aware of.

I am aware of no medical condition that requires deviation from accepted treatment protocols simply because a person is incarcerated and no treatment protocol that is rendered not medically necessary solely because the patient is incarcerated. For these reasons, the SOC expressly state that all elements of the prescribed assessment and treatment are equally applicable to patients in prison (Section XIV), and the National Commission on Correctional Health (NCCHC) recommends treatment in accordance with the SOC for people in correctional settings. *See* NCCHC Position Statement, *Transgender and Gender Diverse Health Care in Correctional Settings* (2020), https://www.ncchc.org/transgender-and-gender-diverse-health-care-in-correctional-settings-2020/.

34. Under the SOC, while it is true that "[r]easonable accommodations to the institutional environment can be made in the delivery of care consistent with the [SOC]," it is also true that "[d]enial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations." SOC at 68.

35. Once a diagnosis of gender dysphoria is made, a treatment plan should be developed based on an individualized assessment of the medical needs of the particular patient.

36. The development of any treatment plan and all subsequent treatment must be administered by clinicians qualified in treating patients with gender dysphoria. The SOC specify the qualifications that professionals must meet in order to provide care to gender dysphoric patients. *See* SOC at Section VII. In particular,

the SOC provide that all mental health professionals should have certain minimum credentials before treating patients with gender dysphoria, including a master's degree (or equivalent) in a clinical behavioral science field; competencies in using the DSM-5 and/or the International Classification of Diseases for diagnostic purposes; ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria; documented supervised training and competence in psychotherapy or counseling; knowledge of gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria; and continuing education in the assessment and treatment of gender dysphoria. SOC at 22.

37. Importantly, the SOC require that "[m]ental health professionals who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria." SOC at 22–23. Self-study cannot substitute for first-hand clinical experience in treating the range of clinical presentations of gender dysphoria, or the mentorship and supervision of an expert in this field.

38. In addition to these minimum credentials, clinicians working with gender dysphoric patients should develop and maintain cultural competence to provide optimal care. A growing body of scientific literature underlies this specialized area of medicine and presents advances in treatment that inform care.

39. Treatment plans generated by providers lacking the requisite experience can result in inappropriate care and can place patients at significant risk.

40. Notably, psychiatric medications are not efficacious in a treatment for gender dysphoria. In addition, while psychotherapy or counseling can provide support and help with the personal and social aspects of a gender transition and may to some extent lessen conditions such as depression and anxiety, psychotherapy and counseling cannot resolve underlying distress due to the incongruence between a person's gender identity and birth-assigned sex. There are no psychotherapeutic interventions that have been demonstrated to be effective in alleviating the gender dysphoria itself and such interventions are not a substitute for medical intervention where medical intervention is needed, nor are they preconditions for such intervention. By analogy, in Type One diabetes, counseling might provide psychoeducation about living with a chronic condition and information about nutrition, but it does not obviate the need for insulin.

41. For many individuals with gender dysphoria, changes to gender expression and role to feminize or masculinize one's appearance, often called "social transition," are an important part of treatment for the condition. This involves dressing, grooming, and otherwise outwardly presenting oneself through social signifiers of gender consistent with one's gender identity. This is an appropriate and necessary part of identity consolidation. Through this experience, the shame of growing up living as a "false self" and the grief of being born into the "wrong body"

can be ameliorated. *See, e.g.*, Greenberg & Laurence (1981); Ettner (1999); Devor (2004).

B. Hormone Therapy

42. For almost all individuals with persistent, well-documented gender dysphoria, hormone therapy is essential and medically indicated treatment to alleviate the distress of the condition. The SOC specify that "feminizing/masculinizing hormone therapy—the administration of exogenous endocrine agents to induce feminizing or masculinizing changes—is a medically necessary intervention for many transsexual, transgender, and gender non-conforming individuals with gender dysphoria." SOC at Section VIII, p. 33.

43. Hormone therapy is a well-established and effective means of treating gender dysphoria. The American Medical Association, the Endocrine Society, the American Psychiatric Association, and the American Psychological Association all agree that hormone therapy in accordance with the WPATH SOC is medically necessary treatment for many individuals with gender dysphoria. *See* AMA Resolution 122; Hembree et al. (2009); APA Policy Statement.

44. The goals of hormone therapy for individuals with gender dysphoria are: (i) to significantly reduce hormone production associated with the person's sex assigned at birth and, thereby, the secondary sex characteristics of the individual's sex assigned at birth; and (ii) to replace circulating sex hormones associated with the person's sex assigned at birth with feminizing or masculinizing hormones, using the principles of hormone replacement treatment developed for hypogonadal patients

(i.e., non-transgender males born with insufficient testosterone or non-transgender females born with insufficient estrogen). *See* Hembree et al. (2009).

45. The therapeutic effects of hormone therapy are twofold: (i) with endocrine treatment, the patient acquires congruent sex characteristics, *i.e.*, for transgender women, breast development, redistribution of body fat, cessation of male pattern baldness, and reduction of body hair; and (ii) hormones act directly on the brain, via receptor sites for sex steroids, which produces an attenuation of dysphoria and attendant psychiatric symptoms, and the promotion of a sense of well-being. *See, e.g.*, Cohen-Kettenis & Gooren (1993).

46. The efficacy of hormone therapy to treat gender dysphoria is observed clinically and is well documented in the literature. For example, in one study, researchers investigated 187 transgender individuals who had received hormone therapy and compared them with a group of transgender individuals who did not. Untreated individuals showed much higher levels of depression, anxiety, and social distress than those who received hormone therapy. *See* Rametti, et al. (2011); *see also* Colizzi et al. (2014); Gorin-Lazard et al. (2014); Gorin-Lazard et al. (2011).

47. Transgender women who have undergone gender-affirming orchiectomy or other gender-affirming genital surgeries resulting in removal of the testicles, like Mrs. Zayre-Brown, must receive consistent gender-affirming hormone therapy at the appropriate therapeutic levels to avoid adverse health effects. Interruption of this essential treatment can result in a lack of lymphocyte production and impaired immunity, hypertension, hypoglycemia, depression, and electrolyte imbalance.

Appropriate laboratory monitoring of hormone therapy should occur every three months for the first year of treatment to validate the efficacy of treatment. Once stability is attained, laboratory monitoring can be done twice a year. Laboratory work should include tests for liver function, complete blood counts, lipid panel, and electrolyte values.

C. Gender-Affirming Surgery

48. For some individuals with severe gender dysphoria, hormone therapy alone is insufficient. For these individuals, relief from their dysphoria cannot be achieved without surgical intervention to modify primary and/or secondary sex characteristics, *i.e.*, genital reconstruction. Under the contemporary understanding of gender identity, transition-related medical treatments confirm, rather than "change," an individual's sex by aligning primary and secondary sex characteristics with a person's gender identity. The WPATH Standards of Care state:

> While many transsexual, transgender, and gender-nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria. . . . For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity.

SOC at 54–55. *See also Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A.*, WPATH (Dec. 21, 2016).[2]

[2] *https://www.wpath.org/newsroom/medical-necessity-statement* ("In some cases, [medical procedures attendant to gender affirming/confirming surgeries] [are]

49. Gender-affirming genital surgery for transgender women has two therapeutic purposes. First, removal of the testicles eliminates the major source of testosterone in the body. Second, through gender-affirming genital surgery, the patient attains body congruence as a result of uro-genital structures appearing and to some extent functioning in ways that are more typical for non-transgender women. Both are critical in alleviating or eliminating gender dysphoria.

50. Decades of careful and methodologically sound scientific research have demonstrated that gender-affirming surgeries are safe and effective treatments for severe gender dysphoria and, indeed, for many people suffering from gender dysphoria, the only effective treatment. *See, e.g.*, Pfäfflin & Junge (1998); Smith et al. (2005); Jarolím et al. (2009).

51. WPATH, the American Medical Association, the Endocrine Society, and the American Psychological Association all support surgery in accordance with the SOC as medically necessary treatment for individuals with severe gender dysphoria. *See* AMA Resolution 122; Hembree et al., at 3148 (2009) ("For many transsexual adults, genital [gender-affirming] surgery may be the necessary step towards achieving their ultimate goal of living successfully in their desired gender role."); APA Policy Statement at 26 (recognizing "the efficacy, benefit and medical necessity of gender transition treatments" and referencing studies demonstrating the effectiveness of gender- affirming surgeries).

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the **only** effective treatment for the condition, and for some people genital surgery is essential and life-saving.") (emphasis in original).

52. Surgeries are considered "effective" from a medical perspective if they "have a therapeutic effect." *See* Monstrey et al. at 95 (2007). More than three decades of research confirms that gender-affirming surgery is therapeutic and therefore an effective treatment for gender dysphoria. As discussed further *infra* ¶¶ 55, 119, regret following gender-affirming surgery is an extremely rare event, with multiple studies indicating it occurs at a rate of less than 1.0%.

53. In a 1998 meta-analysis, Pfäfflin and Junge reviewed data from 80 studies, spanning 30 years, from 12 countries. They concluded that "reassignment procedures were effective in relieving Gender Dysphoria. There were few negative consequences and all aspects of the reassignment process contributed to overwhelmingly positive outcomes." Pfäfflin & Junge (1998) (terminology like "sex reassignment surgery," "sex change surgery," and "transsexual surgery" are obsolete terms referring to the current and more accurate term, gender-affirming surgery.)

54. Numerous subsequent studies confirm this conclusion. Researchers reporting on a large-scale prospective study of 325 individuals in the Netherlands concluded that after gender-affirming surgery there was "a virtual absence of gender dysphoria" in the cohort and "results substantiate previous conclusions that [gender-affirming] surgery is effective." Smith et al. at 94, 89 (2005). Indeed, the authors of the study concluded that the surgery "appeared therapeutic and beneficial" across a wide spectrum of factors and "[t]he main symptom for which the patients had requested treatment, Gender Dysphoria, had decreased to such a degree that it had disappeared." *Id.* at 96.

55. In 2007, Gijs and Brewayes analyzed 18 studies published between 1990 and 2007, encompassing 807 patients. The researchers concluded: "Summarizing the results from the 18 outcome studies of the last two decades, the conclusion that [gender-affirming surgery] is the most appropriate treatment to alleviate the suffering of extremely gender dysphoric individuals still stands: Ninety-six percent of the persons who underwent [surgery] were satisfied and regret was rare." Gijs & Brewayes (2007).

56. In 2018, Cornell University published a literature review called *What Does the Scholarly Research Say about the Effect of Gender Transition on Transgender Well-Being?*[3] The researchers enumerated the following conclusions:

- The scholarly literature makes clear that gender transition is effective in treating gender dysphoria and can significantly improve the well-being of transgender individuals.
- Among the positive outcomes of gender transition and related medical treatments for transgender individuals are improved quality of life, greater relationship satisfaction, higher self-esteem and confidence, and reductions in anxiety, depression, suicidality, and substance use.
- The positive impact of gender transition on transgender well-being has grown considerably in recent years, as both surgical techniques and social support have improved.

[3] What We Know Project, Cornell University (2018), https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-well-being-of-transgender-people/.

- Regrets following gender transition are extremely rare and have become even rarer as both surgical techniques and social support have improved. Pooling data from numerous studies demonstrates a regret rate ranging from .3 percent to 3.8 percent. Regrets are most likely to result from a lack of social support after transition or poor surgical outcomes using older techniques.
- Factors that are predictive of success in the treatment of gender dysphoria include adequate preparation and mental health support prior to treatment, proper follow-up care from knowledgeable providers, consistent family and social support, and high-quality surgical outcomes (when surgery is involved).
- Transgender individuals, particularly those who cannot access treatment for gender dysphoria or who encounter unsupportive social environments, are more likely than the general population to experience health challenges such as depression, anxiety, suicidality, and minority stress. While gender transition can mitigate these challenges, the health and well-being of transgender people can be harmed by stigmatizing and discriminatory treatment.

57. Studies conducted in countries throughout the world likewise conclude that gender-affirming surgery is an extremely effective treatment for gender dysphoria. For example, a 2001 study published in Sweden states: "The vast majority of studies addressing outcome have provided convincing evidence for the benefit of

[gender-affirming] surgery in carefully selected cases." Landen (2001). Similarly, urologists at the University Hospital in Prague, Czech Republic, in a Journal of Sexual Medicine article concluded, "Surgical conversion of the genitalia is a safe and important phase of the treatment of male-to-female transsexuals." Jarolím (2009).

58. Patient satisfaction is an important measure of effective treatment. Achieving functional and normal physical appearance consistent with gender identity alleviates the suffering of gender dysphoria and enables the patient to function in everyday life. Studies have shown that by alleviating the suffering and dysfunction caused by severe gender dysphoria, gender-affirming surgery improves virtually every facet of a patient's life. This includes satisfaction with interpersonal relationships and improved social functioning, *see, e.g.*, Rehman et al. (1999); Johansson et al. (2010); Hepp et al. (2002); Ainsworth & Spiegel (2010); Smith et al. (2005); improvement in self-image and satisfaction with body and physical appearance, *see*, *e.g.*, Lawrence (2003); Smith et al. (2005); Weyers et al. (2009); and greater acceptance and integration into the family, *see*, *e.g.*, Lobato et al. (2006).

59. Studies have also shown that gender-affirming surgery improves patients' abilities to initiate and maintain intimate relationships. *See, e.g.*, Lobato et al. (2006); Lawrence (2005); Lawrence (2006); Imbimbo et al. (2009); Klein & Gorzalka (2009); Jarolím et al. (2009); Smith et al. (2005); Rehman et al. (1999); De Cuypere et al. (2005).

60. Multiple long-term studies have confirmed these results. *See, e.g.*, Vujovic et al. (2009); Weyers et al. (2009); Hepp et al. (2002); Johansson et al. (2010); Imbimbo et al. (2009); Lobato et al. (2006).

61. Given the extensive experience and research supporting the effectiveness of gender-affirming surgery spanning decades, it is clear that such surgery is a medically necessary, not experimental, treatment for severe gender dysphoria as demonstrated by, among other things, its inclusion as a medically necessary treatment in the SOC.

62. In 2008, WPATH issued a "Medical Necessity Statement" expressly stating: "These medical procedures and treatment protocols are not experimental: decades of both clinical and medical research show they are essential to achieving well-being for the transsexual patient."

63. Similarly, Resolution 122 (A-08) of the American Medical Association states: "Health experts in GID, including WPATH, have rejected the myth that these treatments are 'cosmetic' or 'experimental' and have recognized that these treatments can provide safe and effective treatment for a serious health condition."

64. On September 25, 2013, the Department of Health Care Services of the State of California Health and Human Services Agency issued All Plan Letter 13-011, which makes clear that gender confirmation surgery was a covered service for Medi-Cal (California Medicaid) beneficiaries when the surgery was not cosmetic in nature and referred providers to the WPATH SOC for the "criteria for the medical necessity of transgender services."

65. On May 30, 2014, the Appellate Division of the Departmental Appeals Board of the United States Department of Health and Human Services issued decision number 2576, in which the Board determined that a Medicare regulation denying coverage of "all transsexual surgery [outdated terminology for gender-affirming surgery] as a treatment for transsexualism [outdated terminology for gender dysphoria]" was not valid under the "reasonableness standard." The Board specifically concluded that "transsexual surgery is an effective treatment option for transsexualism in appropriate cases."

66. The corpus of studies increases yearly as access to gender affirmation surgery increases. For example, a group at Cornell University conducted a review of 56 studies from 1991 to June 2017 on the outcomes of gender-affirming surgeries for transgender individuals. The results verify the efficacy of surgery: 52 studies (93%) reported beneficial effects, 4 studies reported mixed or null effects, and no studies demonstrated that gender-affirming surgeries cause harm. *What does the scholarly research say about transition on transgender well-being?* Cornell University What We Know: The Public Policy Research Portal (2019), https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-well-being-of-transgender-people/.

D. Living Consistently with Gender Identity

67. The SOC establish the therapeutic importance of changes in gender expression by means of social signifiers that align with gender identity. Gender dysphoria, like many medical conditions, often requires more than a single

intervention for effective treatment. For example, clothing and grooming that affirm one's gender identity, such as bras for transgender females, and the use of pronouns congruent with an individual's gender identity are critically important components of treatment protocols. *See* Greenberg & Laurence (1981); Ettner (1999); Devor (2004).

68. The SOC also specifically provide that permanent hair removal of hair from certain parts of the body and especially the face, which eliminates a particularly visible secondary sex characteristic, is significant in alleviating gender dysphoria for transgender women. Other gender-appropriate grooming items for transgender women such as feminine deodorant, moisturizer, hair care, and make-up may also be necessary for treatment. These accoutrements are critical to the social transition and mental wellbeing of gender dysphoric people.

69. The most commonly pursued gender-affirming medical intervention in transgender women is facial hair removal, as facial hair is an obvious source of distress. Electrolysis and/or laser hair removal are typically required to live safely and comfortably in the affirmed female gender. The removal of hair is an ongoing process for most transgender women, particularly those with dark and coarse hair, and may require numerous treatments. A recent study explored satisfaction with hair removal in relation to gender dysphoria and psychological symptoms in a group of 281 transgender women. Bradford, Rider & Spencer (2019). Results found satisfaction with hair removal correlated with less body dysphoria, less depression and anxiety, and an overall enhanced sense of wellbeing. The authors conclude that

"[t]hese findings cast significant doubt on the assertion that hair removal services for transfeminine people are cosmetic" *Id.*

70. "Misgendering"—the act or referring to a transgender person by the incorrect gender—is harmful to the mental health of transgender persons. It threatens their identity and exacerbates the mental health problems attendant to gender dysphoria. It is therefore important, especially for those charged with the medical treatment and mental health care of transgender persons to use the correct, gender-affirming names and pronouns for them. *See* Bauer et al. (2015); Frost et al. (2015); Bockting (2014).

71. Gender dysphoric prisoners are at heightened risk for depression, anxiety, suicidal ideation, and self-harm without appropriate treatment and care. In addition to the concerns outlined above, it is important for correctional facilities to consider appropriate housing and shower/bathroom facilities for transgender individuals. Each individual's gender identity and role, dignity, and personal safety should be taken into account in housing and other assignments. *See* SOC at 68. If the institution fails to do so, there can be serious consequences for mental and physical health. *See* Seelman (2016).

72. Moreover, incarcerated transgender women with feminine characteristics are at elevated risk for harm when housed in male prisons. Verbal harassment, physical abuse, sexual assault, and sexual coercion of these women occur at an alarming rate, and too often there is inadequate protection.

73. Gender consistent clothing and grooming items are particularly important to provide to transgender patients with gender dysphoria, especially for those individuals who have initiated hormone therapy. The physical changes facilitated by hormones in these patients make gender-affirming clothing and grooming items necessary not only for the mental health of these patients, but also for their basic physical comfort and dignity. For example, for transgender women, female undergarments allow genitals to be tucked and less visible, reducing symptoms of gender dysphoria. Likewise, regardless of breast development, a bra may be an important and affirming symbol of femininity for gender dysphoric transgender women.

74. Social role transition—the ability for a transgender person to appear and live consistent with their gender—has an enormous impact in the treatment of gender dysphoria. An early seminal study emphasized the importance of aligning gender presentation and identity and the benefits of doing so to mental health. Greenberg and Laurence compared the psychiatric status of gender dysphoric individuals who had socially transitioned with those who had not. Those who had implemented a social transition showed "a notable absence of psychopathology" compared to those who were presenting in their birth-assigned sex role. Greenberg & Laurence (1981). In addition, social transition should include use of facilities (restrooms, showers, etc.) that are consistent with one's gender identity. More recently, Sevelius (2013) proposed a "gender affirmation model" which demonstrated that access to gender-affirming components of social role transition equated with

better mental health, fewer suicide attempts, and lower levels of depression and posttraumatic stress disorder (PTSD) symptoms.

E. Risks of Providing Inadequate Care

75. Without adequate treatment, adults with gender dysphoria experience a range of debilitating psychological symptoms such as anxiety, depression, suicidality, and other attendant mental health issues. They are frequently socially isolated as they carry a burden of shame and low self-esteem, attributable to the feeling of being inherently "defective." This leads to stigmatization, and over time proves ravaging to healthy personality development and interpersonal relationships. Without treatment, many gender-dysphoric people are unable to adequately function in occupational, social, or other areas of life. Many gender dysphoric women without access to appropriate care are often so desperate for relief that they resort to life-threatening attempts at auto-castration (the removal of one's testicles) or auto-penectomy (the removal of one's penis). Brown & McDuffie (2009). A recent survey found a 41% rate of suicide attempts among this population, which is far above the baseline suicide attempt rates for North America. Mak et al. (2020).

76. Gender dysphoria intensifies with age. As cortisol (the body's "stress hormone") rises with normal aging, the ratio of dehydroepiandrosterone ("DHEA," a precursor hormone involved in the production of sex hormones—testosterone and estrogen—which decreases with normal aging) to cortisol is affected, which acts to alter brain chemistry and intensify gender dysphoria. With the passage of time, prisoners who require surgical treatment will experience greater distress, and no

means of relief. *See* Ettner (2013); Ettner & Wiley (2013). This is particularly deleterious for transgender prisoners serving long sentences. Because gender dysphoria entails clinically significant and persistent feelings of distress and discomfort with one's assigned gender, if it is not treated, those feelings intensify with time and can become critical. The results are serious and debilitating symptoms of anxiety, depression, and hopelessness. Without adequate, appropriate treatment, these individuals may not be capable of accomplishing simple everyday tasks, and may become increasingly socially withdrawn and isolated, which only serves to further exacerbate their symptoms.

77. Gender dysphoria left untreated or inadequately treated, will result in serious psychological and physical harm. The depression and hopelessness associated with the condition causes suicidal ideation, which will result in actual suicide for many individuals. *See* SOC at 67. Research shows that the risk of suicide can be significantly diminished with prompt and effective treatment. *See, e.g.*, Bauer (2015).

78. Moreover, gender dysphoric individuals have a profound discomfort or disgust of their genitalia. Without effective treatment as outlined above, this often leads to attempts at surgical self-treatment (SST), which can result in lasting physical trauma or death. *See* Brown & McDuffie (2009). Some incarcerated individuals with severe, inadequately treated gender dysphoria have gone so far as to amputate their penis and flush it down a prison toilet as they experience blood loss and possible death from their auto-penectomy. It is also common for prisoners with

severe, inadequately treated gender dysphoria to surreptitiously bind their penis in an attempt to sever it.

79. In sum, the results of providing inadequate treatment are predictable and dire, and take one of three paths: profound psychological decompensation, attempts at surgical self-treatment, or suicidality and suicide.

VII. CLINICAL INTERVIEWS AND ASSESSMENT OF PLAINTIFF KANAUTICA ZAYRE-BROWN

80. Kanautica Zayre-Brown is a 41-year-old transgender woman, assigned male at birth. On May 25, 2022, I conducted an in-person psychological assessment of Mrs. Zayre-Brown at Anson Correctional Institution in Polkton, North Carolina, to evaluate her current psychological and emotional status and the adequacy of the treatment she is receiving for her gender dysphoria. I met with Mrs. Zayre-Brown in a private area and was afforded all the necessary courtesies by the prison staff. My assessment, which lasted approximately four hours, included the administration of three statistically reliable and valid psychometric tests and an extensive clinical interview.

A. Relevant Medical History

81. At 5 feet 11 inches, and 236 pounds, Mrs. Zayre-Brown makes an authentic female presentation. She has long, neatly arranged hair, and tastefully applied make-up. She wore prison issued garments and several tattoos were visible.

82. Mrs. Zayre-Brown has no psychiatric diagnoses. She has been repeatedly diagnosed with gender dysphoria (302.85, DSM-5). Prior to her incarceration, Mrs. Zayre-Brown began her gender transition and underwent several

gender-affirming surgeries beginning in 2011, including breast augmentation, body contouring, ear lobe surgery, and chin implantation. She has also had feminizing surgical facial fillers. Mrs. Zayre-Brown met the WPATH criteria for bilateral orchiectomy (surgical removal of the testes) and underwent the procedure in 2017.[4]

83. Mrs. Zayre-Brown does not smoke cigarettes nor use any illicit substances. She takes no psychotropic medications. Mrs. Zayre-Brown's medical records indicate that, in December 2020, she received sertraline, an anti-depressant medication, during a month-long hospitalization resulting from vocalizing suicidal ideation and a desire to amputate her penis, following an incident in which her gender dysphoria was exacerbated. *See* App. D, at 6-7 Anti-depressants and/or anxiolytics are not efficacious when depression or anxiety are symptoms of gender dysphoria, rather than the result of primary co-occurring mood disorders. Mrs. Zayre-Brown eventually discontinued this medication. In addition, Mrs. Zayre-Browns medical records note that, in April of 2021, Mrs. Zayre-Brown informed her DPS mental health provider that she had a band tied around her penis that had been in place for more than a week due to increased dysphoria from the lack of gender-affirming surgical care. App. D, at 10. These records indicate that Mrs. Zayre-Brown's mental health provider convinced Mrs. Zayre-Brown to remove the band after cautioning her "about the effects of impeding blood flow and risk of infection"[5] and reassuring her

[4] Bilateral orchiectomy was performed in a tissue sparing manner. When this is done, incisions are carefully placed so as not to disrupt future genital reconstruction.

[5] Binding of the penile shaft can result in far worse harms—hydronephrosis (a condition where one or both kidneys became stretched and swollen as the result of a build-up of urine inside them) and kidney failure.

that scheduling for her consult for gender-affirming surgery was in progress. Mrs. Zayre-Brown's medical records further indicate that, in addition to the incident described above, she has expressed similar thoughts regarding auto-penectomy to her DPS mental health care providers on multiple occasions since her December 2020 hospitalizations. *See* App. D, at 8, 12-13. The penis is the essential and, for transgender women, detested evidence of masculinity. Its presence kindles gender dysphoria and creates cognitive dissonance in those who live in their affirmed female gender, yet nevertheless retain this incongruent organ.

84. In 2012, Mrs. Zayre-Brown initiated medically indicated and supervised gender-affirming hormone therapy. However, when she entered DPS custody in 2017, she was denied the essential estrogen she required for eight to nine months. Due to the surgical removal of her testicles, which are responsible for the majority of male testosterone production, Mrs. Zayre-Brown's body is no longer capable of producing endogenous gonadotrophic hormones and she requires regular, sufficient, and gender appropriate prescription hormone therapy. Hormones are essential to the function and maintenance of every organ system in the human body. Absent these crucial endocrine compounds, individuals are physiologically and psychologically at extreme risk for a number of catastrophic occurrences, including lack of lymphocyte production and impaired immunity, hypertension, hypoglycemia, depression, and electrolyte imbalance. During that eight-to-nine-month period, Mrs. Zayre-Brown gained weight, had a marked diminution of energy, and attempted suicide.

85. In addition to the initial unjustified interruption of Mrs. Zayre-Brown's hormone therapy, in January 2019 it was discovered that DPS had not ordered the correct laboratory work for Mrs. Zayre-Brown's hormone therapy appointment with an external provider. Subsequently, the appropriate laboratory work showed that her hormone levels were below the therapeutic range. In April 2019, DPS again failed to provide the required laboratory work for an external endocrinology appointment that Mrs. Zayre-Brown was scheduled for in order to monitor her hormone therapy. From July 2020 until June 2021, Mrs. Zayre-Brown hormone therapy was not being monitored through routine laboratory work. When she was finally seen by an endocrinologist, the laboratory work showed her hormone levels were again not within the therapeutic range. Mrs. Zayre-Brown has also experienced unjustified delays in the timely administration of her hormone therapy, in January 2019 and August 2020, with those delays ranging from days to weeks. In January 2023, Mrs. Zayre-Brown related that she had been waiting for a follow-up appointment with endocrinology for five months, despite concerns about her estradiol levels.

B. Clinical and Psychometric Assessment

86. Mrs. Zayre-Brown was completely cooperative throughout the evaluation process, and I am confident that the opinions I hereafter render are reliable and valid to a reasonable degree of medical certainty. Mrs. Zayre-Brown was able to attend to the entire, lengthy in-person interview with me without agitation or restlessness. She engaged with ease, maintained eye contact throughout, and her affect was appropriate to content. She has no disorders of thought, and thought

processes are logical, goal-directed, and without distortion. Memory and abstract reasoning are well within normal limits. Insight and judgment are good. Language is fluent, speech is natural, and intelligence is above average (by estimation). Mrs. Zayre-Brown has obtained several advanced degrees. She is married and has raised three foster children.

C. Relevant Transition-Related History

87. Born in North Carolina, Mrs. Zayre-Brown was raised by her grandmother. Both biological parents are deceased, and she has a younger half-sister. As early as 5 or 6 years of age, Mrs. Zayre-Brown would wear her grandmother's shoes and put a skirt on her head, pretending it was long, female hair. She never played with boys or engaged in competitive sports as a child.

88. Mrs. Zayre-Brown ultimately left school at 15 or 16 years of age. She wrote worthless checks to purchase female items and was committed to the juvenile justice system. As a teen, Mrs. Zayre-Brown and her family assumed she was "gay." Growing up in an era prior to the existence of "social media" or other readily accessible sources of information, she was unaware that she suffered from a treatable medical condition, namely, gender dysphoria. Although she never felt "masculine," she had no knowledge that there was a name for her persistent feeling of being female. Ultimately, Mrs. Zayre-Brown learned about the concept of being "transgender" from a gay friend, and about the impact of feminizing hormones. In 2010, while working at Humana, Mrs. Zayre-Jones received medically indicated

hormone therapy under the care of a provider at the University of North Carolina at Chapel Hill.

89. While hormone therapy is an essential element of treatment of gender dysphoria, that treatment alone is not sufficient for patients like Mrs. Zayre-Brown, who suffer from severe gender dysphoria. As with all medical conditions, treatment for gender dysphoria must be individualized. Patients who have severe gender dysphoria require both medical and surgical interventions. Individuals with early-onset gender dysphoria that persists into adolescence, like Mrs. Zayre-Brown, typically suffer the most severe symptoms associated with gender dysphoria. By analogy, type-one diabetes appears in childhood and differs from type-two diabetes, which typically is a disease arising in adulthood. The treatment of the conditions can differ, with the latter often being less severe and not necessarily requiring insulin.

90. After years of hormone therapy, Mrs. Zayre-Brown has *been hormonally confirmed*. This means that she has the circulating sex steroid hormones typical for females. Her testosterone levels are in the reference range appropriate for females and indistinguishable from her female peers. She has the secondary sex characteristics of a woman: female breasts, softened skin, diminution of body hair, absence of male pattern baldness, redistribution of body fat consistent with a female-shaped body, loss of muscle mass, and genital changes.

91. On January 9, 2023, I had a follow-up phone consultation with Mrs. Zayre-Brown. At that time her affect was sad, but congruent with content. She was oriented in all spheres. Her though processes were logical and goal directed, without

distortion. Mrs. Zayre-Brown related persistent distress over DPS's continued denial of hair removal, failure to provide counseling competent to address her gender dysphoria, and denial of her needed surgery. She stated that she is constantly "fighting for herself and others" and appears increasingly despondent over DPS's lack of attention to her medical needs.

D. The Inadequacy of Defendants' Treatment of Mrs. Zayre-Brown's Gender Dysphoria

92. I have serious concerns about the adequacy of treatment provided by DPS and its employees for Mrs. Zayre-Brown's gender dysphoria, which falls far outside of what is recommended by the SOC. DPS personnel have been aware of Mrs. Zayre-Brown's gender dysphoria diagnosis and need for treatment, including gender-affirming surgery, since her incarceration, as evidenced by the October 2017 "Mental Health Assessment" by DPS provider Susan Garvey, App. D, at 1-3, and the November 2017 Division Transgender Accommodation Review Committee ("DTARC") "Gender Dysphoria Treatment Plan," App. D, at 4-7.

93. Despite their awareness of Mrs. Zayre-Brown's gender diagnosis and need for treatment, DPS personnel have repeatedly delayed and/or denied providing her with medically necessary treatment. She was inappropriately housed in a male facility for years and denied female clothing and grooming items. Her essential hormone therapy was also inordinately delayed and interrupted, without medical justification or explanation. Since receiving hormone therapy, treatment has been inconsistent and inappropriately evaluated, and follow-up monitoring has been insufficient. Her recent medical consultations have been via teletherapy, which does

not allow palpation to diagnose potential abnormalities secondary to hormonal affirmation. Most egregiously, DPS continues to ignore her serious, urgent, and longstanding medical need for gender-affirming surgery.

94. Mrs. Zayre-Brown has persistently advocated for the surgical treatment she requires. In addition, numerous medical and mental health providers have stated that surgery is a medical necessity for Mrs. Zayre-Brown, including DPS providers Dr. Joseph Umesi (January 2019) and Jennifer Dula (October 2021) and specialty external providers DPS referred Ms. Zayre-Brown to for gender-affirming care, Dr. Brad Figler (July 2021) and Dr. Donald Caraccio (October 2021). Attached as **Appendix E** is a compilation of Mrs. Zayre-Brown's DPS medical records from these four providers, organized chronologically. Nevertheless, DPS officials have repeatedly delayed and denied Mrs. Zayre-Brown's requests for gender-affirming surgery. Attached at **Appendix F** is a compilation of DPS's considerations and denials, organized chronologically. Most recently, in response to Mrs. Zayre-Brown's latest request for gender-affirming surgery (specifically, vulvoplasty) DTARC in a final determination issued on February 17, 2022, wrote "DTARC does not recommend Gender Affirmation surgery. This surgery is not medically necessary."

VIII. DEFICIENCIES IN THE DTARC ZAYRE-BROWN CASE SUMMARY

95. Since the submission of my declarations in this litigation, I have now been provided the DTARC Zayre-Brown Case Summary denying gender-affirming surgery. The Case Summary is attached as **Appendix G**. There are numerous deficiencies in that document.

96. The Case Summary concludes that a vulvoplasty is not medically necessary for Mrs. Zayre-Brown, even though it recognizes that: (a) her "mental health and behavior case reviews indicated no current evidence of any significant comorbid mental health issues"(DAC 3399);(b) review of Mrs. Zayre Brown's "related mental health and behavioral health record indicates the criteria identified by the UNC Transhealth program for appropriateness for surgery have been met," including maintenance of "the minimum weight goal identified by UNC Transhealth program" (DAC 3399); (c) Mrs. Zayre-Brown "has a well-documented, persistent transgender identity," including having "lived as a female in the community" prior to her incarceration, "and has been housed in a female prison since 8/2019" (DAC 3399); (d) she "has completed" a number of "gender-affirming surgeries," including "orchiectomy" and "breast implants," "and has been on hormone replacement therapy" (DAC 3400); (e) on October 4, 2021, a "Transgender Accommodation Summary was completed" that summarized Mrs. Zayre-Brown's "history of transition," as well as her "continued commitment to surgery, current and recent psychological stability, absence of uncontrolled comorbid mental health conditions" and that concluded that Mrs. Zayre-Brown "met appropriate criteria for surgery" (DAC 3399); (f) Mrs. Zayre-Brown "has been educated on the surgical interventions by the UNC Transhealth Program and indicated a preference for vulvoplasty" (DAC 3399); and (g) Mrs. Zayre-Brown is experiencing "anxiety" regarding not having received the surgery she has long sought (DAC 3400).

97. The Case Summary correctly explains, "When treatments are considered for any patient, the most important imperative for physicians is to base recommendations on evidence-based medicine and consideration of that information in the context of the individual patient." (DAC 3400.) Even so, the Case Summary fails to base its conclusion that gender-affirming surgery is not medically necessary for Mrs. Zayre-Brown on evidence-based medicine. Nor does the Case Summary consider that information in Mrs. Zayre-Brown's individual context whatsoever. The latter point is confirmed by the DTARC Position Statement's conclusion that gender-affirming surgery as a treatment for gender dysphoria is *never* medically necessary.

98. The Case Summary does not base its conclusion that a vulvoplasty is not medically necessary for Mrs. Zayre-Brown on anything relating specifically to her medical condition or her individual medical needs, but rather on an incorrect understanding of medical necessity.

99. "Medical necessity" is a term used by the insurance industry and government health care programs to describe treatment that a physician considers to be vital for a particular patient. As DPS was aware, the external providers to whom DPS referred Ms. Zayre-Brown for evaluation of her need for gender-affirming surgery and for gender-affirming care, Dr. Brad Figler and Dr. Donald Caraccio, determined this to be the case for Mrs. Zayre-Brown.

100. According to the American Medical Association ("AMA"), health care is medically necessary when a "prudent physician" selects it for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a

manner that is: (a) in accordance with generally accepted standard of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the convenience of the patient, physician, or other health care provider." AMA Policy H-320.953 (2016). The AMA specifically has recognized that "medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice." AMA Policy H-185.927 (2021). Likewise, the authoritative SOC conclude that, for many transgender individuals, gender-affirming "surgery is essential and medically necessary to alleviate their gender dysphoria."

101. The Case Summary reaches its conclusion that gender-affirming surgery is not medically necessary for Mrs. Zayre-Brown on falsehoods and faulty reasoning. Before discussing those, it is important to note that nowhere in the section of the Case Summary entitled "Medical Analysis" is there any discussion at all of Mrs. Zayre-Brown's medical history, prior treatments, recommendations of health care providers who have examined or treated Mrs. Zayre Brown, her current condition, or the risks to her of not providing gender-affirming summary. (DAC 3400-3403.)

102. Instead, the Case Summary first asserts that "medically necessary treatments, and this is particularly true of surgical procedures, consist of a single, or at most a very discrete subset of surgeries" and that this is not the case of gender-affirming surgery "where there are wide range of treatments … which are presented as 'options' in treatment, are largely determined by patient's desires." (DAC 3400.)

103. Whether treatment of a condition consists of a single or discrete subset of procedures is irrelevant to determining medical necessity. This assertion ignores that different treatments may be medically necessary for different patients and particularly depend on the severity of the condition in a particular patient, the patient's response to other attempted treatments, any comorbidities, contraindications, and risks to the patient of not providing the treatment.

104. In addition, treatment of other medical conditions recognized as medically necessary often include a wide range of treatments. For example, treatments for various forms of cancer may include hormone therapy, chemotherapy, hyperthermia (heating of the body to help damage and kill cancer cells with little or no harm to normal tissue), immunotherapy, photodynamic therapy (using a drug activated by light to kill cancer and other abnormal cells), radiation therapy, and a range of surgeries. In addition, particularly for patients with severe gender dysphoria like Mrs. Zayre-Brown, gender-affirming surgery may be the only available option and its need is determined by medical professionals who have examined a patient, not simply "a patient's desires."

105. Second, the Case Summary describes a procedure being necessary as "treatment required in order to protect life, to prevent significant disability, or to alleviate pain." (DAC 3400.) My examination of Mrs. Zayre-Brown and her medical history demonstrate that gender-affirming surgery actually is necessary to protect her life given the risks of suicide in failing to provide such surgery, to prevent the

ongoing disability she is suffering from due to her extreme gender dysphoria, and to alleviate the psychological pain she has long experienced and continues to experience.

106. Third, the Case Summary asserts that, barring complications to surgery, for it to be medically necessary, most individuals suffering from gender dysphoria would have to seek to have such surgery, whereas only 25-35% of transgender individuals ever undergo any form of gender-affirming surgery. (DAC 3400.) This reasoning is faulty as well. Like all medical conditions, gender dysphoria exists on a continuum. By analogy, patients can have glucose intolerance, metabolic syndrome, type 2 diabetes, or the most severe, type 1 diabetes. The most severe forms tend to have early onset and treatment decisions vary depending on severity. The same is true for Mrs. Zayre-Brown. She has exhausted treatments that might be sufficient for individuals who have a less severe condition and yet she continues to have surgical self-treatment ideation, which is a symptom of severe gender dysphoria. The statement that only 25-35% of individuals with gender dysphoria undergo gender-affirming surgery is consistent with the fact that not all individuals *require* such surgery, whereas Mrs. Zayre-Brown does. Moreover, some individuals whose severe gender dysphoria would be alleviated by gender-affirming surgery may have medical issues that preclude surgery or may not have sources to pay for such surgery. These facts align with the Case Summary's recognition that treatment of any patient must be based on "the context of the individual patient." (DAC 3400.)

107. Fourth, the Case Summary asserts, "Almost universally, medically necessary procedures are by definition covered by insurance carriers" and that this is

not the case regarding gender-affirming surgery. Even were this assertion true even in other contexts, it fails to consider the historical, medically unjustified and discriminatory conclusion of many insurance carriers that gender-affirming surgery is cosmetic or experimental.

108. In addition, the largest insurance companies and nonprofit health care plans in the United States now have policies that include coverage of gender-affirming surgery when medically necessary, including Aetna, Alliant, Anthem, Assurant, Blue Cross, Brown & Toland HMO, Cigna, Excellus (Blue Cross/Blue Shield of New York), Health Net, Hills Physicians (HMO), Humana, Kaiser Permanente, and United Health Insurance. For example, Aetna considers gender-affirming surgery medically necessary when guidelines derived from the WPATH Standards of Care have been met. Likewise, the corporate policy of Blue Cross/Blue Shield is to provide such coverage, recognizing and referencing the WPATH SOC (see BCBS Corporate Medical Policy) and Blue Cross Blue Shield of North Carolina now covers gender-affirming surgeries. Similarly, Kaiser Permanente, one of the largest nonprofit healthcare plans in the United States, "supports members pursuing gender-affirming surgeries through established pathways of care."

109. The Case Summary also asserts that "64% (32 States) of the U.S. Medicaid programs do not offer coverage" for gender-affirming surgeries. This information is outdated. A Journal of Sexual Medicine (2021) article reports that 25 of the 51 state Medicaid programs do cover gender-affirming surgery. For example, MassHealth *Guidelines for Medical Necessity Determination for Gender Affirming*

Surgery (which applies to both the state's Medicaid program) states that such surgery "may be part of the therapeutic treatment to better align physical characteristics with gender identity."[6]

110. The Case Summary also falsely asserts that the North Carolina State Employees Health Plan does not cover the cost of gender-affirming surgery. (DAC 3400.) While that plan previously ceased covering such care, which it had provided in 2017, it resumed doing so last year after a federal court held the denial of such coverage unconstitutional. Similar changes have occurred over the last several years in other state employee health insurance plans as a result of federal lawsuits, including in Georgia and Wisconsin.

111. In addition, at the federal level, the Veterans Health Administration, the largest health care system in the United States, treats veterans largely based on guidelines set forth in the SOC and references those standards in their national training practices. Likewise, a previous Medicare exclusion of gender-affirming surgery was eliminated in 2014 following the Appellate Division of the Departmental Appeals Board of the United States Department of Health and Human Services decision number 2576, referred to above in this report, which concluded that "transsexual surgery is an effective treatment option for transsexualism in appropriate cases," and there is now no national exclusion for transition-related health care under Medicare. Instead, coverage for gender-affirming surgery is

[6] MassHealth, Guideline for Medical Necessity Determination for Gender-Affirming Surgery at 1 (Sept. 1, 2021), https://www.mass.gov/doc/gender-affirming-surgery/download.

decided on a case-by-case basis, as with Medicare handles coverage for most other medical treatments, based on whether gender-affirming surgery is medically necessary for the individual beneficiary after considering the individual's specific circumstances.

112. Fifth, the Case Summary states, that "Medically necessary treatments must be based on standards of practice, must be evidence-based, peer-reviewed, and without bias or conflict of interest among the researchers or agency providing the necessity of the treatment, and there is almost always consensus among the medical community as to not only the necessity of the treatment/ procedure, but further, the preferred statement" (see DAC 3400). The Case Summary then states that, in the case of gender-affirming surgery in the treatment of gender dysphoria, "none of these factors are true." (DAC 3400.) That is demonstrably false. As explained elsewhere in this report, the medical necessity of gender-affirming surgery for certain patients suffering from gender identity actually is supported by nearly universally accepted standards of practice, which rest on evidence-based, peer-reviewed research.

113. The Case Summary discussion of WPATH in particular is riddled with erroneous assertions. For example, as noted above, AMA, the Endocrine Society, the American Psychological Association, the American Psychiatric Association, the World Health Organization, the American Academy of Family Physicians, the American Public Health Association, the National Association of Social Workers, the American College of Obstetrics and Gynecology and the American Society of Plastic Surgeons all endorse treatment protocols in accordance with the SOC, and numerous courts

have recognized the SOC as authoritative. In addition, the team that conducted the evidence review for the 8th version of the SOC was not composed of WPATH members, but other professionals at Johns Hopkins University. Further, the Case Summary asserts that "[t]he majority of the members of the WPATH Committee are from the U.S., and six of them have affiliations with the same university—the University of Minnesota Program in Sexuality, which is primarily funded by a transgender advocacy organization (Tawani Foundation)." (DAC 3401). This statement is particularly puzzling. There is no one WPATH Committee. WPATH has many committees, including Bylaws, Policies & Procedures, Child and Adolescent, Disorders of Sex Development (previously Intersex), Ethics, Institutionalized Persons, Legal Issues, Member Communication and Technology, Public Policy Advocacy and Liaison, Standards of Care Revision, Voice and Communication, and the Global Education Institute. WPATH has more than 2,700 members, representing 49 countries, with chapters throughout the world, including EPATH (Europe), and ASIAPATH. Moreover, the Tawani Foundation is not a "transgender advocacy organization," but rather a grantmaking foundation that focuses on numerous issues, including education, the environment, cultural institutions and historical preservation, and health and human services, in addition to gender and human sexuality.

114. Finally on these points, the Case Summary's suggestion that the Endocrine Society Guidelines are questionable (DAC 3401) is refuted by the fact that those evidence-based guidelines were co-sponsored by, among others, the American

Association of Clinical Endocrinologists, the American Society of Andrology, the European Society for Endocrinology, and the Pediatric Endocrine Society.[7]

115. Sixth, the Case Summary's reliance on the 2016 Centers for Medicaid and Medicare Decision Memo (DAC 3401-3402) ignores the research of the last six years; the United States Department of Health and Human Services rejection of Medicare's previous exclusion of gender-affirming surgery and conclusion that such surgery is "an effective treatment option" in appropriate cases; and Medicare's determination that coverage for gender-affirming surgery should be decided on a case-by-case basis, based on whether gender-affirming surgery is medically necessary for the individual. As noted elsewhere in this report, research demonstrates that, contrary to the assertions in the Case Summary, individuals who have had gender-affirming surgery experience long-term mental and behavioral health benefits and improved quality of life; complications of gender-affirming surgery are infrequent; and regret after gender-affirming surgery and detransition are rare.

116. The Case Summary's assertion that "[n]o studies conclusively demonstrate that [gender-affirming surgery] improves quality of life or sufficiently addresses gender dysphoria" (DAC 3402) is contradicted by the literature addressing

[7] The Clinical Guidelines Subcommittee of the Endocrine Society deemed the diagnosis and treatment of individuals with gender dysphoria/gender incongruence a priority area for revision and appointed a task force to formulate evidence-based recommendations. The task force followed the approach recommended by the Grading of Recommendations, Assessment, Development and Evaluation group, an international group with expertise in the development and implementation of evidence-based guidelines. The task force commissioned two systematic reviews to support the guidelines.

such surgery and particularly recent studies substantiating the health outcomes and benefits of gender-affirming surgery. For example, in a 2021 study published in *JAMA Surgery* involving 27,715 transgender individuals from across all 50 states (the largest existing data set containing information on the benefits of gender-affirming surgery), researchers compared transgender individuals who underwent gender-affirming surgeries during the prior two years with a reference group that desired surgery but had not yet undergone any. After controlling for sociodemographic factors, those who had undergone surgery had significantly less psychological distress, tobacco use, and suicidal ideation than those with no history of surgery. The authors conclude: "These findings support the provision of gender affirming surgeries for TGD (transgender and gender diverse) people who seek them." In addition, a systematic meta-analysis on publications performed by German researchers included 1,100 post-surgery participants. Seven different measures of quality of life were employed. The researchers concluded that gender-affirming surgery positively affects well-being, sexuality, and quality of life in general. Weinforth, et al., 2019. This is consistent with other research that has shown that transgender individuals who undergo gender-affirming surgery experience long-term mental health benefits. In one study, a person's odds of needing mental health treatment declined by 8% each year after receiving gender-affirming surgery. Indeed, most people who have such surgery experience an improvement in their quality of life. Depending on the procedure, 94% to 100% of people report being satisfied with their surgery results.

117. The Case Summary also distorts the research it cites. For example, it mischaracterizes the results of the *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden* (commonly referred to as "the Swedish study") regarding suicide rates, mortality, and psychiatric hospitalization after gender-affirming surgery. Dr. Dhenje, the study's primary researcher, has publicly disavowed mischaracterization of her investigation.[8] I have a professional relationship with Dr. Dhenje and she has informed me that her study should not be interpreted to mean that gender-affirming surgery leads to an increase in suicide rates. In addition, Dr. Dhenje has stated publicly that the study was not designed to evaluate the outcome of gender transition and does not say that transition causes people to commit suicide. According to Dr. Dhejne, only the transgender people who transitioned before 1989 had slightly higher rates of suicide attempts than the general public (but still far lower than pre-transition levels for transgender people). Any observed trend in suicide rates following gender-affirming surgery cannot be held as evidence that surgery leads to increased rates of suicide without a comparison to rates of suicide pre-surgery, which is generally not studied due to ethical issues of internationally withholding treatment for purposes of research. Indeed, Dr. Dhejne's

[8] *On Gender Dysphoria*, Dep't of Clinical Neuroscience, Karolinska Institute, at 65 (Stockholm, Sweden 2017) ("Our findings have been used to argue that gender-affirming treatment should be stopped. But the results have also been used to show the vulnerability of the group and that better transgender health care is needed (Arcelus & Bouman, 2015; Zeluf et al., 2016). . . . Most of the articles that use the study to argue against gender affirming health care are published in non-peer reviewed papers and the public media in general. . . . I am grateful to friends, colleagues . . . and journalists who have alerted me when the results of the study have been misinterpreted[.]").

study states, "For the purpose of evaluating whether sex reassignment is an effective treatment for gender dysphoria, it is reasonable to compare reported gender dysphoria pre and post treatment. Such studies have been conducted either prospectively or retrospectively, and suggest that sex reassignment of transsexual persons improves quality of life and gender dysphoria." Dr. Dhenje also has stated that "recent studies conclude that WPATH Standards of Care compliant treatment decrease gender dysphoria and improve mental health."

118. The Case Summary also relies on highly questionable sources of information. Its reliance on a study by the Society for Evidence-Based Gender Medicine ("SEGM"), asserting that 70% of those who transitioned were dissatisfied with their decision to do so (DAC 3402-3403) is particularly suspect. SEGM is not recognized as a scientific organization, but rather is an activist organization known for mischaracterizing standards of care for transgender individuals. Researchers at the Yale School of Medicine issued a report which described SEGM as a small group of anti-trans activists. Boulware, S., Komody, R., et al. (2022) Biased Science: The Texas and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims, Yale Law School Public Law Research. SEGM lacks transparency in its membership, membership criteria, and the identity of its board of directors. A commentary published in the journal *Clinical Practice in Pediatric Psychology* described them as outside the medical mainstream. Kuper, L., Cooper, M., Mooney, M. (2022) Supporting and advocating for transgender and gender diverse youth and their

families within the sociopolitical context of widespread discrimination legislation and policies," Clinical Practice in Pediatric Psychology, **10** (3): 336-345, *doi:10.1037/cpp000456. ISSN 2169-4834.* A spokesperson for the Endocrine Society also described them as outside the medical mainstream.

119. Contrary to the assertions in this SEGM "study," research indicates that regret in adults who transition is extremely low, at about 1%. A recent study found regret rates of 0.2-0.3%. The authors characterized the nature of regret and found much of it was due to social exclusion and/or poor surgical outcomes. Narayan et al. (2021). Complications of gender-affirming surgeries are comparatively low. A recent study found that fewer than 6% of more than 1,000 patients who underwent gender-confirming surgeries suffered some complications. Lane, et al. 2018. By comparison, women who underwent the common procedure of breast reduction had a complication rate of 43%. Salim & Poh (2019). Vulvoplasty has an even lower complication rate than vaginoplasty. According to the Cleveland Clinic, the most common complications are bleeding from the incision for a day or two, itching at the cite, bruising, and swollen labia. Recovery usually takes no more than two weeks. The therapeutic effects of vulvoplasty include, most importantly, genitals that appear normal (resulting in attenuation or cure of gender dysphoria), as well as the ability to urinate when sitting and the possibility of orgasm. At a recent meeting of the American Society for Reconstructive Microsurgery, at which I delivered a presentation for the Society of Gender Surgeons, surgeons estimated that approximately 30% of surgeries performed to treat gender dysphoria are vulvoplasty rather than vaginoplasty.

120. The assertions in the Case Summary regarding detransition (DAC 3402) are especially questionable and are not relevant to whether gender-affirming surgery is medically necessary for Mrs. Zayre-Brown. Most of that research was done on minors before current standards for diagnosis of gender dysphoria among children and adolescents existed and reflects minors who may have been mischaracterized as transgender when they actually were simply displaying gender-nonconforming behaviors, such as preferring toys traditionally associated with a sex different than they were assigned at birth. More current research has found that only 2.5% of transgender minors go through detransition, while the majority of young people keep their gender identity after five years.

121. In summary, the Case Summary fails to provide any medically-valid justification for concluding that a vulvoplasty is not medically necessary for Mrs. Zayre-Brown, as the medical providers to whom DPS sent Mrs. Zayre-Brown for evaluation and treatment concluded and as my examination of Mrs. Zayre-Brown has confirmed. Quite troublingly, the Case Summary fails to consider at all the consequences for Mrs. Zayre-Brown of not receiving gender-affirming surgery, including the existing and ongoing risks to her life from suicide or surgical self-treatment, as well as to her mental health and well-being and her ongoing, extreme suffering. DPS presents no discussion of alternative treatments for alleviating Mrs. Zayre-Brown's severe gender dysphoria, which persists notwithstanding the treatment she has received to date for her condition.

IX. DEFICIENCIES IN THE DTARC POSITION STATEMENT THAT GENDER-AFFIRMING SURGERY IS NEVER MEDICALLY NECESSARY.

122. The DTARC Position Statement, which is attached hereto as **Appendix H** and which was issued by DPS shortly after the Zayre-Brown Case Summary, is plagued with most of the same defects as the Case Summary. .

123. The Position Statement states, "As with all treatments, including procedures and surgeries provided to offenders, the first consideration is whether the treatment is medically necessary," and adds, "This consideration is precisely the same as that utilized by every managed care system and health insurance agency in the Country." (DAC 3405.)

124. The Position Statement asserts that "GRS procedures fail to satisfy the criteria and characteristics evidenced by" "other procedures and surgeries which are broadly considered medically necessary" because "there are concerns that the risk, as defined by failure of the procedure to correct the underlying problem or the need for subsequent reversal of the procedure outweigh any potential benefit of the procedure." (DAC 3405.) As shown *supra* ¶¶ 50-66, 111, and 116-17, however, gender-affirming surgery has been shown to be extremely effective in alleviating and, in many cases, eliminating gender dysphoria. In nearly all cases of individuals who undergo gender-affirming surgery, there is no need for reversal of the procedure. It thus cannot be said that the potential benefit of the procedure is categorically outweighed by its risks for every single patient.

125. Like the Case Summary, the Position Statement asserts that, for a procedure to be medically necessary, there needs to be consensus among the medical community that not undertaking the procedure will fail to alleviate the symptoms of the condition—and could result in death, severe disability, or significant worsening of the condition. (DAC 3407.) There *is* such a consensus among the medical community with respect to patients suffering from severe gender dysphoria like Mrs. Zayre Brown. As explained *supra* ¶¶75-79, withholding recommended gender-affirming surgery from someone with severe gender dysphoria could result in death due to suicide or surgical self-treatment, as well as severe disability resulting from ongoing gender dysphoria and significant worsening of gender dysphoria that occurs as individuals with that condition age.[9]

126. The Position Statement reiterates the fallacy in the Case Summary that surgical treatment for gender dysphoria is unlike medically necessary surgeries for other conditions because there is a wide spectrum of options to treat gender dysphoria. (DAC 3409.) As discussed *supra* ¶ 104, treatment of gender dysphoria is no different in this regard than numerous other conditions that may require different surgeries depending on the severity of the condition, previous attempted treatments for the condition that have failed to adequately address it, and other factors. While

[9] The studies referred to in the Position Statement regarding these issues (DAC 3407-3408) are largely the same as those relied on in the Case Summary and reliance on them suffers the same defects as already discussed *supra* ¶¶ 116-19, including the Position Statement's mischaracterization of the Swedish study, its assertions regarding detransition research, and its assertions regarding purported regret after gender-affirming surgery.

there are no tests resembling a CT Scan, MRI, or biopsy to determine indications for particular gender-affirming surgeries, there are widely-accepted diagnostic criteria that do not rest on patient "choice" that must be met before gender-affirming surgery is recommended. That some advocacy groups may want gender-affirming surgery to be available "without the requirement of external evaluations or therapy by mental health professionals," (DAC 3410) is irrelevant. Gender-affirming genital surgeries are not done in the United States without such external evaluations and prior efforts to treat gender dysphoria.

127. As explained regarding the Case Summary, *see supra* ¶ 106, the assertion in the Position Statement that "only 25-35% of individuals with gender dysphoria" undergo gender-affirming surgery (DAC 3410) does not show it is not medically necessary for particular individuals with severe gender dysphoria, such as Mrs. Zayre-Brown. Likewise, as further explained *supra* ¶¶ 108-11 of this report with regard to the Case Summary, the Position Statement's assertions regarding the health plans of insurance carriers, Medicare, state Medicaid, and state employees' health plans (specifically including North Carolina's) asserted lack of coverage for gender-affirming surgeries (DAC 3410) are seriously inaccurate.

128. As to the Position Statement's assertions regarding the number of individuals who have received gender-affirming surgeries in prison (DAC 3411), whether a treatment is medically necessary is not determined by prison practices, regardless of how widespread violations of prisoners' rights to obtain medically necessary care may be. Moreover, the federal Bureau of Prisons recently settled

litigation brought by an incarcerated transgender woman by agreeing to provide her gender-affirming surgery and has contracted with a surgeon to perform a vaginoplasty and breast augmentation for another incarcerated transgender woman and, as the Position Statement admits (see DAC 3411), some states have provided such surgeries to prisoners. Contrary to the assertions in the Position Statement that the only provisions of gender-affirming surgery were "very discrete circumstances in court settlements," between August 8, 2015 and November 8, 2019, the California Department of Corrections and Rehabilitation ("CDCR") granted 17 requests of prisoners for gender-affirming surgery. Moreover, in July 2021, the CDCR updated its care guidelines to provide that "Gender affirming surgery may be considered for those individuals who are diagnosed with Gender Dysphoria and demonstrate significant distress not attributable to conditions of confinement, mental illness or other factors, but are due to lack of reasonable response to available nonsurgical treatments and there are no available, additional treatments other than surgery that are likely to improve or alleviate their symptoms." In addition, in Illinois, gender-affirming surgery has been performed on at least one transgender prisoner and several more such surgeries have been scheduled; and a prisoner serving a life-sentence in Massachusetts underwent vaginoplasty while incarcerated, under the state's Medicaid policy.

129. The Position Statement's critique of the evidence supporting gender-affirming surgery as a treatment for gender dysphoria (DAC 3412-3414) lacks validity, again making numerous assertions already rebutted above. *See supra* ¶¶ 30,

111-17. As with the Case Summary, this critique relies on unwarranted criticisms of WPATH that belie the consensus among the nation's leading medical and mental health professional organizations and the courts that look to WPATH and the SOC for authoritative guidance about the treatment of gender dysphoria. It also relies extensively on SEGM, which is an outlier, anti-transgender organization, as discussed above. The Position Statement's assertions that the evidence base for treatment for gender dysphoria is of low quality belies knowledge of research methodology. "Low quality evidence" refers to certain types of studies and does not mean that the evidence is poor or should not be relied upon. Indeed, a significant portion of medical treatment decisions are made in reliance upon "low quality" evidence. Many common surgical and medical interventions reported by the Cochrane Review (a collection of high quality, independent evidence to inform healthcare decision-making) have the same level of evidence as gender-affirming surgery, including, for example: rotator cuff surgery, which 4,600 Americans undergo yearly; appendectomy; early versus delayed surgery; exercise-based cardiac rehab post heart valve surgery, and many more.

130. The Position Statement's assertion that performance of gender-affirming surgeries may violate physicians' obligation to "do no harm" (DAC 3414) demonstrates how distorted the Position Statement is. It has been estimated that approximately 9,000 gender-affirming surgeries are done in the United States annually, with the number increasing each year, and such surgeries are done at some of the nation's leading medical institutions. To suggest that all of those who have

conducted the tens of thousands of such surgeries in our nation alone may be violating their ethical obligations is an extremist and unwarranted claim. Moreover, the Position Statement altogether ignores the harm that is done by failing to provide gender-affirming surgery to those experiencing severe gender dysphoria.

X. ERRONEOUS STATEMENTS, OPINIONS, AND CONCLUSIONS MADE BY JOSEPH PENN, MD AND SARA BOYD, PH.D., ABPP

131. Earlier in this case, the Defendants submitted affidavits from Dr. Joseph Penn and Dr. Sarah Boyd critiquing my initial declaration and indicating support for the Defendants' refusal to provide Mrs. Zayre-Brown gender-affirming surgery. I then submitted a second declaration explaining why Dr. Penn and Dr. Boyd's views were incorrect, irrelevant, or both. ECF No. 22-1. I incorporate my second declaration here by reference.

XI. CONCLUSIONS AND OPINIONS

132. There is broad consensus in the medical community that, for some individuals diagnosed with gender dysphoria, gender-affirming surgery is medically necessary when other treatment is unlikely to alleviate the patient's symptoms, prevent further emotional and psychological pain, and prevent associated physical harm.

133. Mrs. Zayre-Brown has severe and persistent gender dysphoria. She continues to struggle with thoughts of auto-penectomy, the "last resort" to eliminate gender dysphoria. She consolidated her female identity long ago but cannot resolve the anatomical dysphoria resulting from having male genitalia and a female gender

identity in an otherwise female body. Her previous treatments for gender dysphoria, many of which have been inconsistently or inadequately provided by DPS, have been ineffective in significantly alleviating or resolving that condition.

134. With normal aging, cortisol levels increase. For gender dysphoric individuals, elevated cortisol alters brain chemistry and intensifies gender dysphoria. Mrs. Zayre-Brown's gender dysphoria will continue to intensify, with no means of relief. Her immediate need for surgery is great and will only accelerate.

135. Mrs. Zayre-Brown is unusually well-adjusted and has shown remarkable resilience given my understanding of her experiences in DPS custody. But her resilience is rapidly eroding. She has met, and exceeded, all the requirements of the WPATH SOC for surgical intervention, which is medically necessary to treat her severe gender dysphoria. My understanding is that decisions regarding gender-affirming surgery for DPS prisoners are made by the DTARC and are subject to the approval of the Deputy Commissioner and the Director of Health and Wellness. But medical decisions, and especially decisions about whether a patient should receive or be denied treatment, are rarely proper for committees, especially committees composed of individuals without expertise in the condition being treated. In this case, the records I have reviewed indicate that the healthcare providers with expertise in treating gender dysphoria were overridden by DTARC members for non-medical reasons.

136. In sum, having reviewed Mrs. Zayre-Brown's medical records, assessed her in-person, and followed up with her by phone, I conclude that Mrs. Zayre-Brown urgently requires gender-affirming genital surgery to treat her gender dysphoria.

137. In denying Mrs. Zayre-Brown gender-affirming surgery, the Defendants do not appear to have provided any consideration for her individual circumstances, which they concede is a critical step for evaluating medical necessity. Instead, the Defendants appear to believe that gender-affirming surgery is never medically necessary for anyone, regardless of individual circumstances. That view is totally inconsistent with the modern understanding of gender dysphoria. It also is inconsistent with the understanding of any number of medical conditions—simply because one treatment is not medically necessary for one patient, or even most patients, does not mean it is never necessary.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 2nd day of February, 2023.

Dr. Randi Ettner Ph.D

Dr. Randi Ettner, Ph.D.

CERTIFICATE OF SERVICE

I hereby certify that on February 3, 2023, as agreed upon by the parties, I served the foregoing **EXPERT REPORT OF DR. RANDI C. ETTNER, PH.D.** on Defendants' counsel of record via email as follows:

Orlando L. Rodriguez
Special Deputy Attorney General
orodriguez@ncdoj.gov

Stephanie A. Brennan
Special Deputy Attorney General
sbrennan@ncdoj.gov

/s/ Jaclyn A. Maffetore
Jaclyn A. Maffetore
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APPENDIX A

RANDI ETTNER, PHD
1214 Lake Street
Evanston, Illinois 60201
847-328-3433

POSITIONS HELD

Clinical Psychologist
Forensic Psychologist
Fellow and Diplomate in Clinical Evaluation, American Board of Psychological Specialties
Fellow and Diplomate in Trauma/PTSD
President, New Health Foundation Worldwide
Past Secretary, World Professional Association for Transgender Health (WPATH)
Chair, Committee for Institutionalized Persons, WPATH
Global Education Initiative Committee Curriculum Development, WPATH
University of Minnesota Medical Foundation: Leadership Council
Psychologist, Center for Gender Confirmation Surgery, Weiss Memorial Hospital
Adjunct Faculty, Prescott College
Editorial Board, *International Journal of Transgender Health*
Editorial Board, *Transgender Health*
Television and radio guest (more than 100 national and international appearances)
Internationally syndicated columnist on women's health issues
Private practitioner
Medical staff; Department of Medicine: Weiss Memorial Hospital, Chicago, IL
Advisory Council, National Center for Gender Spectrum Health
Global Clinical Practice Network; World Health Organization
Harvard Law School LGBTQ Clinic Leadership Council

EDUCATION

PhD, 1979	Northwestern University (with honors) Evanston, Illinois
MA, 1976	Roosevelt University (with honors) Chicago, Illinois
BA, 1969-73	Indiana University Bloomington, Indiana Cum Laude Major: Clinical Psychology; Minor: Sociology
1972	Moray College of Education Edinburgh, Scotland International Education Program
1970	Harvard University Cambridge, Massachusetts Social Relations Undergraduate Summer Study Program in Group Dynamics and Processes

CLINICAL AND PROFESSIONAL EXPERIENCE

2016-2022	Psychologist: Weiss Memorial Hospital Center for Gender Confirmation Surgery
	Consultant: Walgreens; Tawani Enterprises
	Private practitioner: clinical and forensic practice
2011	Instructor, Prescott College: Gender-A multidimensional approach
2004-2009	Consultant to Wisconsin Public Schools
2000	Instructor, Illinois School of Professional Psychology
1995-present	Supervision of clinicians in counseling gender non-conforming clients
1993	Post-doctoral continuing education with Dr. James Butcher in MMPI-2 Interpretation, University of Minnesota
1992	Continuing advanced tutorial with Dr. Leah Schaefer in psychotherapy
1983-1984	Staff psychologist, Women's Health Center, St. Francis Hospital, Evanston, Illinois
1981-1984	Instructor, Roosevelt University, Department of Psychology: Psychology of Women, Tests and Measurements, Clinical Psychology, Personal Growth, Personality Theories, Abnormal Psychology
1976-1978	Research Associate, Cook County Hospital, Chicago, Illinois, Department of Psychiatry
1975-1977	Clinical Internship, Cook County Hospital, Chicago, Illinois, Department of Psychiatry
1971	Research Associate, Department of Psychology, Indiana University
1970-1972	Teaching Assistant in Experimental and Introductory Psychology Department of Psychology, Indiana University
1969-1971	Experimental Psychology Laboratory Assistant, Department of Psychology, Indiana University

INVITED PRESENTATIONS AND HOSPITAL GRAND ROUNDS

Shifting Sands: Challenges in Providing Surgical Care American Society of Reconstructive Microsurgery, Miami, FL 2023

The Standard of Care for Institutionalized Persons WPATH 27th Scientific Symposium, Montreal, Canada 2022

Healthcare for Transgender Prisoners Rush University, Department of Plastic and Reconstructive Surgery, Chicago, IL 2022

Sexual Function: Expectations and outcomes for patients undergoing gender-affirming surgery. Whitney, N., Ettner, R., Schechter, L. Rush University, Department of Plastic and Reconstructive Surgery, Chicago, IL 2022

Care of the Older Transgender Patient, Weiss Memorial Hospital, Chicago, IL, 2021

Working with Medical Experts, The National LGBT Law Association, webinar presentation, 2020

Legal Issues Facing the Transgender Community, Illinois State Bar Association, Chicago, IL, 2020

Providing Gender Affirming Care to Transgender Patients, American Medical Student Association, webinar presentation, 2020

Foundations in Mental Health for Working with Transgender Clients; Center for Supporting Community Development Initiatives, Vietduc University Hospital, Hanoi, Vietnam, 2020

Advanced Mental Health Issues, Ethical Issues in the Delivery of Care, Development Initiaves, Vietduc University Hospital, Hanoi, Vietnam, 2020

The Transgender Surgical Patient, American Society of Plastic Surgeons, Miami, FL 2019

Mental health issues in transgender health care, American Medical Student Association, webinar presentation, 2019

Sticks and stones: Childhood bullying experiences in lesbian women and transmen, Buenos Aires, 2018

Gender identity and the Standards of Care, American College of Surgeons, Boston, MA, 2018

Expectations of individuals undergoing gender-confirming surgeries Schechter, L., White, T., Ritz, N., Ettner, R. Buenos Aires, 2018

The mental health professional in the multi-disciplinary team, *pre-operative evaluation and assessment for gender confirmation surgery,* American Society of Plastic Surgeons, Chicago, IL, 2018; Buenos Aires, 2018

Navigating transference and countertransference issues, WPATH Global Education Initiative, Portland, OR; 2018

Psychological aspects of gender confirmation surgery International Continence Society, Philadelphia, PA 2018

The role of the mental health professional in gender confirmation surgeries, Mt. Sinai Hospital, New York City, NY, 2018

Mental health evaluation for gender confirmation surgery, Gender Confirmation Surgical Team, Weiss Memorial Hospital, Chicago, IL 2018

Transitioning; Bathrooms are only the beginning, American College of Legal Medicine, Charleston, SC, 2018

Gender Dysphoria: A medical perspective, Department of Health and Human Services, Office for Civil Rights, Washington, D.C, 2017

Multi-disciplinary health care for transgender patients, James A. Lovell Federal Health Care Center, North Chicago, IL, 2017

Psychological and Social Issues in the Aging Transgender Person, Weiss Memorial Hospital, Chicago, IL, 2017

Psychiatric and Legal Issues for Transgender Inmates, USPATH, Los Angeles, CA, 2017

Transgender 101 for Surgeons, American Society of Plastic Surgeons, Chicago, IL, 2017

Healthcare for transgender inmates in the US, Erasmus Medical Center, Rotterdam, Netherlands, 2016

Tomboys Revisited: Replication and Implication; Amsterdam, Netherlands, 2016

Orange Isn't the New Black Yet- Care for incarcerated transgender persons, WPATH symposium, Amsterdam, Netherlands, 2016

Can two wrongs make a right? Expanding models of care beyond the divide, Amsterdam, Netherlands, 2016

Foundations in mental health; WPATH Global Education Initiative, Chicago, IL 2015

Role of the mental health professional in legal and policy issues, WPATH Global Education Initiative, Chicago, IL 2015

Healthcare for transgender inmates; WPATH Global Education Initiative, Chicago, IL 2015

Children of transgender parents; WPATH Global Education Initiative; Atlanta, GA, 2016

Transfeminine genital surgery assessment: WPATH Global Education Initiative, Columbia, MO, 2016

Foundations in Mental Health; WPATH Global Education Initiative; Ft. Lauderdale, FL, 2016; Washington, D.C., 2016, Los Angeles, CA, 2017, Minneapolis, MN, 2017, Chicago, IL, 2017; Columbus, Ohio, 2017; Portland, OR, 2018; Cincinnati, OH, 2018, Buenos Aires, 2018.

Pre-operative evaluation in gender affirming surgery-American Society of Plastic Surgeons, Boston, MA, 2015

Gender affirming psychotherapy; Assessment and referrals for surgery-Standards of Care-Fenway Health Clinic, Boston, 2015

Transgender surgery- Midwestern Association of Plastic Surgeons, Chicago, 2015

Adult development and quality of life in transgender healthcare- Eunice Kennedy Shriver National Institute of Child Health and Human Development, 2015

Healthcare for transgender inmates- American Academy of Psychiatry and the Law, Chicago, 2014

Supporting transgender students: best school practices for success- American Civil Liberties Union of Illinois and Illinois Safe School Alliance, 2014

Addressing the needs of transgender students on campus- Prescott College, Prescott, AZ, 2014

The role of the behavioral psychologist in transgender healthcare – Gay and Lesbian Medical Association, 2013

Understanding transgender- Nielsen Corporation, Chicago, 2013

Role of the forensic psychologist in transgender care; *Care of the aging transgender patient* University of California San Francisco, Center for Excellence, 2013

Grand Rounds: Evidence-based care of transgender patients- North Shore University Health Systems, University of Chicago, Illinois, 2011

Grand Rounds: *Evidence-based care of transgender patients* Roosevelt-St. Vincent Hospital, New York, 2011

Grand Rounds: *Evidence-based care of transgender patients* Columbia Presbyterian Hospital, Columbia University, New York, 2011

Hypertension: Pathophysiology of a secret. WPATH symposium, Atlanta, GA, 2011

Exploring the Clinical Utility of Transsexual Typologies Oslo, Norway, 2009

Children of Transsexual Parents-International Association of Sex Researchers, Ottawa, Canada, 2005

Children of Transsexual Parents- Chicago School of Professional Psychology, Chicago, 2005

Gender and the Law- DePaul University College of Law, Chicago, Illinois, 2003

Family and Systems Aggression against Providers, WPATH Symposium, Ghent, Belgium 2003

Children of Transsexual Parents-American Bar Association annual meeting, New York, 2000

Grand Rounds: Gender Incongruence in Adults, St. Francis Hospital, 1999.

Gender Identity, Gender Dysphoria and Clinical Issues –WPATH Symposium, Bangkok, Thailand, 2014; Argosy College, Chicago, Illinois, 2010; Cultural Impact Conference, Chicago, Illinois, 2005; Weiss Hospital, Department of Surgery, Chicago, Illinois, 2005; Resurrection Hospital Ethics Committee, Evanston, Illinois, 2005; Wisconsin Public Schools, Sheboygan, Wisconsin, 2004, 2006, 2009; Rush North Shore Hospital, Skokie, Illinois, 2004; Nine Circles Community Health Centre, University of Winnipeg, Winnipeg, Canada, 2003; James H. Quillen VA Medical Center, East Tennessee State University, Johnson City, Tennessee, 2002; Sixth European Federation of Sexology, Cyprus, 2002; Fifteenth World Congress of Sexology, Paris, France, 2001; Illinois School of Professional Psychology, Chicago, Illinois 2001; Lesbian Community Cancer Project, Chicago, Illinois 2000; Emory University Student Residence Hall, Atlanta, Georgia, 1999; Parents, Families and Friends of Lesbians and Gays National Convention, Chicago, Illinois, 1998; In the Family Psychotherapy Network National Convention, San Francisco, California, 1998; Evanston City Council, Evanston, Illinois 1997; Howard Brown Community Center, Chicago, Illinois, 1995; YWCA Women's Shelter, Evanston, Illinois, 1995; Center for Addictive Problems, Chicago, 1994

Psychosocial Assessment of Risk and Intervention Strategies in Prenatal Patients- St. Francis Hospital, Center for Women's Health, Evanston, Illinois, 1984; Purdue University School of Nursing, West Layette, Indiana, 1980

Psychonueroimmunology and Cancer Treatment- St. Francis Hospital, Evanston, Illinois, 1984

Psychosexual Factors in Women's Health- St. Francis Hospital, Center for Women's Health, Evanston, Illinois, 1984.

Grand Rounds: Sexual Dysfunction in Medical Practice- St. Francis Hospital, Dept. of OB/GYN, Evanston, Illinois, 1990

Sleep Apnea - St. Francis Hospital, Evanston, Illinois, 1996; Lincolnwood Public Library, Lincolnwood, Illinois, 1996*The Role of Denial in Dialysis Patients* - Cook County Hospital, Department of Psychiatry, Chicago, Illinois, 1977

PUBLICATIONS

Coleman, E., Radix, A., Bouman, W., Brown, G., deVries, A.L., Deutsch, M., Ettner, R., et. al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *International Journal of Transgender Health*, 23:sup1S1-S259.

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Narayan, S., Danker, S Esmonde, N., Guerriero, J., Carter, A., Dugi III, D., Ettner, R., Radix A., Bluebond-Langner, R., Schechter, L., Berli, J. (2021) Guiding the conversation: Types of regret after gender-affirming surgery and their associated etiologies. *Annals of Translational Medicine,*9(7):605.

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Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W., Monstrey, S., Adler, R., Brown, G., Devor, A., Ehrbar, R., Ettner, R., et.al. Standards of Care for the health of transsexual, transgender, and gender-nonconforming people. World Professional Association for Transgender Health (WPATH). 2012.

Ettner, R., White, T., and Brown, G. Family and systems aggression towards therapists. *International Journal of Transgenderism,* Vol. 12, 2010.

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Monstrey, S. De Cuypere, G. and Ettner, R. Surgery: General principles in Principles of Transgender Medicine and Surgery, Ettner, R., Monstrey, S., and Eyler, E. (Eds.) Routledge Press, 2007.

Schechter, L., Boffa, J., Ettner, R., and Ettner, F. Revision vaginoplasty with sigmoid interposition: A reliable solution for a difficult problem. The World Professional Association for Transgender Health (WPATH), 2007, *XX Biennial Symposium,* 31-32.

Ettner, R. Transsexual Couples: A qualitative evaluation of atypical partner preferences. *International Journal of Transgenderism,* Vol. 10, 2007.

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Confessions of a Gender Defender: A Psychologist's Reflections on Life amongst the Transgender. Chicago Spectrum Press. 1996.

Post-traumatic Stress Disorder, *Chicago Daily Law Bulletin*, 1995.

Compensation for Mental Injury, Chicago Daily Law Bulletin, 1994.

Workshop Model for the Inclusion and Treatment of the Families of Transsexuals, Proceedings of the Harry Benjamin International Gender Dysphoria Symposium; Bavaria, Germany, 1995.

Transsexualism- The Phenotypic Variable, Proceedings of the XV Harry Benjamin International Gender Dysphoria Association Symposium; Vancouver, Canada, 1997.=*The Work of Worrying: Emotional Preparation for Labor* in Pregnancy as Healing. A Holistic Philosophy for Prenatal Care, Peterson, G. and Mehl, L. Vol. II. Chapter 13, Mindbody Press, 1985.

PROFESSIONAL AFFILIATIONS

University of Minnesota Institute for Sexual and Gender Health–Leadership Council

American College of Forensic Psychologists

World Professional Association for Transgender Health

New Health Foundation Worldwide

World Health Organization (WHO) Global Access Practice Network

TransNet national network for transgender research

American Psychological Association

American College of Forensic Examiners

Society for the Scientific Study of Sexuality

Screenwriters and Actors Guild

Phi Beta Kappa

AWARDS AND HONORS

University of Minnesota, Institute for Sexual and Gender Health; 50 *Distinguished Sex and Gender Revolutionaries* award, 2021

Letter of commendation from United States Congress for contributions to public health in Illinois, 2019

WPATH Distinguished Education and Advocacy Award, 2018

The Randi and Fred Ettner Transgender Health Fellowship-Program in Human Sexuality, University of Minnesota, 2016

Phi Beta Kappa, 1972

Indiana University Women's Honor Society, 1970-1972

Indiana University Honors Program, 1970-1972

Merit Scholarship Recipient, 1970-1972

Indiana University Department of Psychology Outstanding Undergraduate Award Recipient, 1970-1972

Representative, Student Governing Commission, Indiana University, 1970

LICENSE

Clinical Psychologist, State of Illinois, 1980

APPENDIX B

JON L. STRYKER AND SLOBODAN RANDJELOVIĆ
LESBIAN GAY BISEXUAL TRANSGENDER QUEER & HIV PROJECT

JAMES D. ESSEKS
DIRECTOR

ACLU
AMERICAN CIVIL LIBERTIES UNION FOUNDATION

National Office
125 Broad Street, 18th floor
New York NY 10004
(212) 549-2500
aclu.org

February 24, 2022

By Email
Randi Ettner, PhD.
rettner@aol.com

Re: Expert witness engagement for the matter of Kanautica Zayre-Brown

Dear Dr. Ettner:

This will memorialize the terms of the agreement under which you have been retained by the American Civil Liberties Union ("ACLU") and the American Civil Liberties Union of North Carolina ("ACLU of NC") to perform professional services in connection with the above-referenced matter.

We have retained you for services in connection with the above-referenced matter from time to time. We may request these services orally or in writing. This assignment shall potentially include, but not be limited to, preparing a declaration and/or expert report, which may be used in connection with the lawsuit. We expect that you will apply your professional judgment, knowledge, expertise, and expertise to assist us. You shall undertake no work under this agreement unless specifically requested to do so by us. Whenever you believe additional work that we have not requested is necessary or appropriate, you will let us know so we can decide whether to authorize it.

Your work under this agreement will be personally directed and supervised by Taylor Brown of the ACLU, Jon W. Davidson of the ACLU, Jaclyn Maffetore of the ACLU of NC, and other attorneys at the ACLU and/or the ACLU of NC.

Compensation shall be computed on an hourly rate for actual time devoted, at:

- $375.00 per hour for any clinical services, records review, or report drafting in conjunction with this matter;
- $475.00 per hour for any deposition or trial testimony.

You should submit bills on a regular basis directly to ACLU by emailing bills to Jon W. Davidson at jondavidson@aclu.org. Such bills should generally describe the activities performed in the time for which you are billing and the dates on which those activities were performed, as the time spent on each activity (rounded up to the nearest 1/10 of an hour). For example:

8/2/22	Draft expert report	1.3 hours
8/2/22	Phone conversation with Attorney X. Smith related to drafting report	.5 hours

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AMERICAN CIVIL LIBERTIES UNION FOUNDATION

The ACLU and the ACLU of NC agree to pay $2,500.00 per day for any necessary travel in conjunction with this matter. Additionally, the ACLU and the ACLU of NC agree to pay any reasonable out-of-pocket expenses incurred. Any out-of-pocket expenses including copying and mailing costs paid by you for the purpose of completing your obligations under this agreement will be promptly reimbursed upon submission of an invoice, receipts, or other valid statements of expense, provided that, in order for any single expense of over $200.00 to be reimbursable by counsel, that expense must be approved by us prior to being incurred. Any change in compensation rates must be agreed upon in writing. Your compensation does not depend on the outcome of this litigation, the opinions you express, or the testimony you provide.

Any and all studies, reports, or other data or information gathered, collected, or prepared by or for you in fulfillment of this retention shall be our property and shall be delivered to us upon our request or upon completion of your services under this agreement.

You understand that your work under this agreement is for us and is done at our request as attorneys in aid of litigation, and that all work performed by you under this agreement, including but not limited to all communications, whether written or oral, between you and any attorney or employee of the ACLU or the ACLU of NC, are confidential and privileged communications which you will not reveal to any other person, except as authorized by us in advance or required by law, with

prior notice to us. In this regard, you agree to inform each of your employees or agents performing services under this agreement of the confidentiality obligations set forth herein.

You also understand that you need to preserve any written materials, including e-mails, generated or received by you in connection with this engagement, as such materials are potentially discoverable in litigation, and, by entering into this retention, you agree that you will do so.

It is understood that during the course of your engagement you will adhere to all applicable ethical and legal standards.

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AMERICAN CIVIL LIBERTIES UNION FOUNDATION

This agreement shall not be assigned, or transferred, in whole or in part by either party without the previous written consent of the other party, and any attempt to do so shall be void and unenforceable.

Counsel may decide, in their discretion, to terminate their engagement of you and/or withdraw the request that you serve as a witness at deposition or trial. Additionally, you may terminate your engagement. If you terminate your engagement, you will provide notice of termination in writing to counsel at least thirty (30) days prior to the termination of engagement.

If either party exercises its right of termination, you shall, if requested by counsel, bring to an orderly conclusion any project or projects on which you are then working in connection with this agreement and deliver your work product to counsel within thirty (30) days of the notice of termination. In the unlikely event that you terminate your engagement less than sixty (60) days before trial, you will deliver your work product to counsel within five (5) days of the notice of termination.

This agreement shall be governed and interpreted according to the laws of the State of New York. This letter agreement, when signed by you, shall constitute the entire agreement between you and us with respect to this matter.

If you agree to the terms set forth above, please print and sign and return this agreement to me electronically.

Very truly yours,

/s/ Jon W. Davidson
Jon W. Davidson
Senior Staff Attorney
ACLU LGBTQ & HIV Project
jondavidson@aclu.org | P: 323-536-9880

ACLU
AMERICAN CIVIL LIBERTIES UNION FOUNDATION

APPROVED AND AGREED TO:

By: Randi Ettner PhD
Randi Ettner, PhD.

APPENDIX C

BIBLIOGRAPHY

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Boulware, S., Komody, R., et al. (2022) Biased science: The Texas and Alabama measures criminalizing medical treatment for transgender children and adolescents rely on inaccurate and misleading scientific claims, *Yale Law School Public Law Research.*

Bradford, N., Rider, CN. & Spencer, K. (2019). Hair removal and psychological well-being in transfeminine adults: associations with gender dysphoria and gender euphoria. *Journal of Dermatological Treatment*, 32(6):635-642.

Brown, G. (2010) Auto-castration and auto-penectomy as surgical self-treatment in incarcerated persons with Gender Identity Disorder. *International Journal of Transgenderism, 12: 31-39*.

Brown, G. & McDuffie, E. (2009) Health care policies addressing transgender inmates in prison systems in the US. *Journal of Correctional Health.*

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APPENDIX D

North Carolina Department of Public Safety
Mental Health Assessment

Offender Name: [redacted] Off #: 0618705
Date of Birth: [redacted]/1981 Sex: M Facility: CRAV
Date: 10/13/2017 09:30 Provider: Garvey, Susan C M.A. Staff

Treatment Setting

Outpatient Program at CRAVEN CI.

Referral

Nursing

Violence Alerts

There are no elevated risk factors presently noted for inmate CHESTNUT.

Escape Alerts

There are no elevated risk factors presently noted for inmate CHESTNUT.

Self-Injury Alerts

There are no elevated risk factors presently noted for inmate CHESTNUT.

Current Problems

Inmate [redacted] is a 36 year old, African American male who reports he identifies as transgender, mate to female. He reports he has undergone breast augmentation, hormone replacement therapy, and an orchiectomy (removal of testicles). He reports he had the orchiectomy on August 25, 2017. He reports prior to beginning the surgeries for transformation, he participated in counseling at UNC Chapel Hill School of Psychiatry.

Inmate [redacted] reports he was around the age of 17 when he "came out" as gay. He states "I lived a gay lifestyle until I was 29." He reports it has been within the last 5 years he has begun his transition to becoming a female. When asked about how he saw himself as a child, he replies "I acted boyish but presented as feminine. I was confused. I fought a lot." He then states "I always had an inclination to change."

Inmate [redacted] reports he legally changed his name to Kanautica Zayre in 2011, through Wake County. He states he would like to be referred to by his legal name while incarcerated instead of the name he provided at the time of his arrest. He reports in December 2012, he began seeing a psychologist through UNC Healthcare, so he could be approved to begin his transition to becoming a woman. He reports after eight months in counseling, he was approved to begin having surgeries and to receive hormones. He states he began hormones prior to surgeries which include estrogen, progestin, and spermalactin (blocks testosterone and is described is required pre-castration). Prior to his orchiectomy, he reports he was seen again by his psychologist at UNC Healthcare, for approval and/or clearance to undergo this surgery. He states he was given two letters by his psychologist stating he was ready to have these surgeries completed. He reports his psychologist's name was Neffateria Hans.

Inmate [redacted] reports he began having surgery in May 2017 with a Brazilian Butt Lift. He reports in October 2013, he had breast implant surgery. He reports his third surgery involved a facial fat transfer in which fat was transferred to his forehead jaw, chin, and cheeks. He reports this process also concealed his Adam's Apple. He notes this surgery, as well as a surgery to feminize his ear lobes, were completed in July 2017. He reports just prior to being incarcerated, he had an orchiectomy, in which his testicles were removed. He notes his last surgery is to have a vaginoplasty. He reports he has spent approximately $57,000 on surgeries.

Inmate [redacted] reports he feels more like a woman with each surgery, which he notes is comforting to him. When asked how he would describe himself to others, he replies "A breath of fresh air. I always try to smile."

History

Inmate [redacted] reports his mother was 13 years old when she gave birth to him so he was primarily raised by his maternal grandparents, [redacted] He states after this occurred, he often ran away from home to avoid any further abuse. He reports after he first ran away, he was placed in the Kennedy Home for two years. He states shortly after he returned home, he ran away again, and then was sent to Samarkand for a few months and then was transferred to Eckerd Youth Camp. He reports he returned home after he completed the youth camp. He states shortly after he returned home, he stole his teacher's car. He reports he did not receive any charges but was sent to Dobbs Training

School for four months. He reports after he returned to his grandparents after being released from Dobbs, he was sent to live with his mother in Raleigh. He reports his mother then "disappeared" and he returned to his grandparents. He reports at this point, his grandparent were told if they did not legally adopt him, he would be placed in a foster home. He states despite being adopted, he was sent back to the Kennedy Home. He reports he was sent back to his grandparents after being sexually harassed while at the Kennedy Home.

Inmate [redacted] states his mother is gay and describes her as a "stud." He reports she recently passed away from breast cancer. He reports his mother was hospitalized once after an unsuccessful suicide attempt.

Inmate [redacted] reports he has been with his spouse, Dionne Brown, since August 2011. He reports he and his spouse were married shortly after the court ruling on same sex marriages, on October 24, 2014. He notes since he began having surgeries to change his body, he and his spouse have "grown apart." He reports his spouse believes he is changing too fast. Inmate Chestnut reports the rapidness of his changes have boosted his self-esteem.

Inmate [redacted] reports he completed the 11th grade and then did not return to school to graduate. He denies being held back any grades. He reports he was in honor's classes and part of the school's Honor's Society. He reports a history of suspension for fighting. He denies any history of expulsion. He indicates continuing his education in 2004 through Mayland Community College in Spruce Pines, NC. He reports from 2005 through 2009, he took courses through University of North Carolina and earned an Associate's Degree in Sociology. He reports he began working on his Bachelor's of Social Work while incarcerated at Avery-Mitchell CI. He reports he completed his Bachelor's of Social Work after his release, through an online program with Michigan State University in 2013.

Inmate [redacted] reports from 2009 through 2013, he worked began as a direct care employee and moved to a Qualified Professional for Supreme Love Inc, group homes owned by a family member. He reports from 2013 through 2016, he worked as a Program Supervisor for Holly Hill Hospital. He reports he was an instructor for NCI and CPI. He reports he also worked part time for the Autism Society during this period. He reports from 2016 through September 2017, he worked "nightlife and dancing" at "exotic" strip clubs.

Inmate [redacted] denies any significant medical conditions at this time. Please refer to medical encounters regarding recent medical diagnoses. He denies any significant history of head injury. He reports a family history of hypertension and cancer.

Inmate [redacted] denies any mental health treatment history outside of what is required for a transgender individual to have treatments or surgeries. He denies any history of inpatient mental health treatment. He denies any history of taking psychotropic medications. He denies any history of engaging in self-injurious or suicidal behavior.

Inmate [redacted] reports a history of alcohol and marijuana use. He states his last use was approximately four years ago. He denies any history of substance abuse treatment.

Inmate [redacted] is currently serving a 7 year, 5 month to 9 year, 11 month sentence for charges of Habitual Felon, Obtaining Property by False Pretense, and Insurance Fraud. Per OPUS, he has 125 days of jail credit towards his sentence. Per OPUS, his projected release date is currently unaudited.

Interview/MSE

Inmate [redacted] was informed of the limits of confidentiality as they pertain to the state prison system. He is appropriately dressed in prison attire and demonstrates proper personal hygiene. Alert and oriented in all spheres. Inmate denies current or recent suicidal or homicidal ideation or intent. He denies any current or recent self-injurious behaviors or destructive ideations. Inmate [redacted] did not present with any paranoid or delusional ideation. His speech was normal in rate and volume. No flight of ideas, loose associations, or pressure was noted. Mood and affect are unremarkable.

Assessment

According to the DSM-V, inmate [redacted] meets the criteria for a diagnosis of Gender Dysphoria in Adolescents and Adults (302.85) based on the following markers...

Inmate [redacted] has expressed an interest in openly living as a female since the age of 29. He notes the incongruence between his expressed gender and primary and/or secondary sex characteristics are of significant distress to him, especially given he has one more surgery to complete his full transition to becoming a female. He reports he has undergone several treatments and surgeries already to have his male primary and secondary characteristics changed to meet his expressed gender.

Diagnosis

302.85 Gender Dysphoria in Adolescents and Adults

Plan

Per Health Services policy (TX I-13), a multidisciplinary treatment team will be formed and will interview inmate [redacted] and review all available records. This will occur at his receiving facility. Once this psychologist is aware of the unit he will transfer, they will be informed of the need to bring together a treatment team. The treatment team will develop an individualized treatment plan. The mental health assessment and psychiatric assessment will be made available to the treatment team to the extent necessary for treatment decisions and recommendations.

Diagnosis:

Gender Dysphoria in Adolescents and Adults, 302.85 - Current, Chronic, Initial

Schedule:

Activity	Date Scheduled	Scheduled Provider
Mental Health Progress Note F/U	11/10/2017 00:00	Garvey, Susan C Staff Psychologist

Co-Pay Required: No **Cosign Required:** No
Telephone/Verbal Order: No
Standing Order: No

Completed by Garvey, Susan C M.A. Staff Psychologist on 11/01/2017 10:37
Requested to be reviewed by Peiper, Lewis J Ph.D Asst. Dir. of Beh. Health.
Review documentation will be displayed on the following page.

North Carolina Department of Public Safety

Prisons

Roy Cooper, Governor
Erik A. Hooks, Secretary

W. David Guice, Commissioner
George T. Solomon, Director

GENDER DYSPHORIA TREATMENT PLAN

Inmate: [redacted]
OPUS #: 0618705
DOB: [redacted]/1981 (age 36)
Facility: Harnett Correctional Institute, 3805

Review Panel Date: 11/27/2017
Review Panel Members:
Joseph Umesi, MD, primary care provider who completed physical examination
Phillip Graham, Predoctoral Intern, inmate's assigned clinician under the supervision of:
Marcia L. Brumbaugh, PhD, Psychological Program Manager
Tammy Black, RN, Nursing Supervisor
Melanie Shelton, Assistant Superintendent of Programs

The panel interviewed inmate [redacted] on the above date and reviewed relevant records, including the 10/18/2017 Psychiatric Evaluation by Dr. Hamra; the 10/12/2017 History and Physical records by Dr. Engleman; and the 10/13/2017 Mental Health Assessment by Ms. Garvey (all are attached).

Diagnosis: 302.85 (F64.1) Gender Dysphoria in Adolescents and Adults

Accommodations Requested: Inmate [redacted] requested the following accommodations during his panel interview:
-Privacy during showers, with a request to shower during count time if possible. He also requested that not as many staff be present during his showers. (He was informed that these requests are consistent with the facility SOP, which will be followed henceforth.)
-That he receive mail under his alias name Kanuatica Zayre. (He reports that he legally changed his name in 2011; community records scanned into HERO confirmed this alias.)
-He requested that records that contain his aforementioned alias be included with his recognized name ([redacted]) in the NCDPS system.
-Inmate requested documents to have his name legally changed, noted and included in the NCPDS system with a badge to reflect his name change. (He was informed of how to complete the process.)
-He inquired about why his UR request for hormones treatment was cancelled. (Inmate was informed that policy only allows for continuation of hormone treatment that was active immediately prior to incarceration, which records verify is not the case for this inmate, and so he does not meet criteria for pursing UR approval during processing. He was further informed that the purpose of the current meeting is to seek approval for endocrinologist consultation.)

MAILING ADDRESS:
Post Office Box 1569
Lillington, N.C. 27546
COURIER: 14-70-02
www.ncdps.gov

OFFICE LOCATION:
Harnett Correctional Institution, #3805
1210 E. McNeill Street
Lillington, N.C. 27546
Telephone: (910) 893-2751
Fax: (910) 893-6432

- Bras (Please note that he currently has 5 bras but reported that he has "gained weight" and requires bras to accommodate the changes in his body. He was informed that he would need to have his measurements updated and placed on the list for the next clothing shipment.)
-Inmate requested the grooming and hygiene policy for women. (Inmate was informed that panel members are not aware of such gender specific polices but will check.)
-Inmate inquired about how to move forward with completing his gender reassignment surgery. He inquired if it would be possible. (Dr. Umesi informed the inmate that he will need to follow up and let him know at a later date.)

Psychiatric Referral: Not indicated, as inmate [redacted] was already seen in Psychiatry Clinic, most recently by Dr. Badri Hamra for a Psychiatric Evaluation. Neither psychiatric medication nor psychiatry appointments were indicated.

Other Appropriate Referrals: The panel recommends referring inmate [redacted] to Endocrinology for consideration of cross-sex hormone treatment. Inmate stated his goal is to have a "more feminine appearance," and he inquired if the "State" will follow up with his request to continue with gender reassignment surgery.

Education Resources to Make Available: None. Inmate reports being familiar with the process due to having done "extensive research."

Management Recommendations: The panel recommends housing inmate [redacted] in a single cell environment. This recommendation was made in consideration for the well-being of the inmate's safety due to his vulnerable status as a trans-female housed in a male facility.

Submitted by:

Phillip Graham, B.A. 7/28/2017
Date
Predoctoral Intern, Harnett Correctional Institute

Marcia L. Brumbaugh, PhD 11/28/17
Date
Psychological Program Manager, Harnett Correctional Institute

cc: Central Office Transgender Review Committee, Facility Review Panel and Administrators
Ms. Tammy Black, Nurse Manager, Harnett Correctional Institute
Ms. Terri Catlett, Health Services Deputy Director
Mr. Jamie Cobb, Assistant Superintendent of Custody, Harnett Correctional Institute
Dr. Patricia Hahn, Assistant Director of Behavioral Health, Triangle Region
Dr. Bryan Harrelson, Acting Chief of Psychiatry
Dr. Gary Junker, Director of Behavioral Health
Ms. Melanie Shelton, Assistant Superintendent of Programs, Harnett Correctional Institute
Dr. Paula Smith, Director of Health Services
Ms. Cynthia Thornton, Correctional Administrator I, Harnett Correctional Institute
Dr. Joseph Umesi, Physician

North Carolina Department of Public Safety
Self-Injury Risk Assessment

Offender Name: [redacted] Off #: 0618705
Date of Birth: [redacted]981 Sex: F Facility: ANSO
Date: 12/11/2020 11:20 Provider: Hahn, Patricia M Ph.D Asst. Dir. of Beh. Health

Type of Housing: Restrictive Housing

FINDINGS

This assessment and the resulting recommendations are based on the following sources of information:
Clinical Interview

Reason for Referral

Ms. [redacted] has experienced a worsening of Gender Dysphoria due to recent events and currently expressed self-injurious and suicidal ideation.

Treatment Setting

Outpatient Program at Anson CI.

Current Self-Injurious Behaviors

Ms. [redacted] indicated she has thoughts of "ripping the skin off my pee-pee."

Current Plan to Self-Injure

Ms. [redacted] currently has no plan to self-injure but is having very frequent thoughts of self-mutilation.

Current Suicidal Ideation

Ms. [redacted] stated she wants to be given a medication that will "put me to sleep and keep me asleep." When asked for clarification, she stated "I don't want to die but I feel like it is the best thing for me."

Current Suicidal Intent

Ms. [redacted] does not have a current plan to kill herself.

Current Mental Status

Level of Consciousness: Alert and Oriented

Psychomotor Activity: Normal

General Appearance: Normal

Behavior: Cooperative

Mood: Sad/depressed

Thought Process: Appropriate

Thought Content: Other

RISK AND PROTECTIVE FACTORS ASSESSED:

This writer screened the offender for a variety of empirically validated factors commonly associated with risk for self-harm.

The following **STATIC** risk factors were assessed to be present and may increase the inmate's risk for engaging in suicide related behaviors: Chronic Medical Condition, Family history of inpatient psychiatric treatment, Family history of suicide attempt, History of childhood abuse (physical or sexual), History of mental illness, History of self-injurious behavior

The following **DYNAMIC** risk factors were assessed to be present and may increase the inmate's risk for engaging in suicide related behaviors: Anxiety/Panic, Current suicidal ideation, Fear for own safety, Feeling hopeless/helpless, Feeling like a burden to others, Inability to feel pleasure, Sleep problems, Social isolation, Uncontrolled mental health symptoms

The following **PROTECTIVE** factors were assessed to be present and may decrease the inmate's risk of suicide: Able to cope with stress, Able to identify reasons to live, Adequate problem solving skills, Future orientation, Responsibility to loved ones/children, Supportive family relationships, Willingness to engage in treatment

Ms. [redacted] has had an increase in symptoms of Gender Dysphoria since August, which have been addressed in therapy but not yet with medication because she was trying to stay off medication. She has had increasing problems coping with institution issues and on November 23 got in an altercation with another offender who implied Ms. [redacted] still had a penis -- one of her greatest current fears is that someone will find out she still has part of a penis so it is an extremely emotionally arousing issue

for her. Since that time, Ms. [redacted] symptoms of depression have significantly increased, and she has had thoughts of ripping the skin of her penis and thinks she may be better off dead.

RECOMMENDATIONS

Suicide Watch: Place on Self-Injury Precautions.

Completed by Hahn, Patricia M Ph.D Asst. Dir. of Beh. Health on 12/11/2020 14:19

North Carolina Department of Public Safety
Mental Health Progress Note

Offender Name: [redacted] Off #: 0618705
Date of Birth: [redacted]/1981 Sex: F Facility: ANSO
Date: 02/19/2021 11:05 Provider: Hahn, Patricia M Ph.D Asst. Dir.

Treatment Setting

Outpatient Program at Anson CI.

Reason for Services

Routine Follow-Up Session

Violence Alerts

Ms. [redacted] denied any current thoughts of wanting to harm others.

Escape Alerts

None currently noted.

Self-Injury Alerts

Ms. [redacted] denied any current thoughts or plans of wanting to harm herself; however, at times she does have thoughts of self-mutilation to get rid of the remaining part of her penis.

MSE/Behavioral Observations

Ms. [redacted] presented as a polite 39 year old Black -American female who appeared approximately her stated age. She was pleasant and cooperative during the therapy session. She displayed good eye contact and had no significant psychomotor agitation or retardation. Her speech was of normal rate, rhythm and volume. She was oriented to person, place, and time. Her attention and immediate memory appeared within normal limits. Her affect was somewhat dysphoric, ands he described her mood as "I don't know . . . I'm dull." She denied current suicidal or homicidal ideation. She did not currently show active symptoms of psychosis or a thought disorder. Her judgment and insight were at least fair.

Progress Towards Goal(s)

Ms. [redacted]s main issue continues to be that her consult appointment with the urologist has not yet been scheduled. The barriers to this scheduling were discussed but it was unclear what has actually happened since there were some discrepancies between what each of us have been told. The main discrepancy is that it is unclear whether Ms. [redacted] is supposed to have her consult first or whether she is supposed to wait for her vaginoplasty to be approved by DPS. Ms. [redacted] stated one of her DTARC forms said Dr. Junker and Deputy Commissioner Harris agree with the disapproval of the vaginoplasty until the surgery consult was completed but HERO would not open the DTARC notes so this could not be immediately confirmed (and the undersigned wanted to finish her note). The undersigned will try to update Dr. Peiper before the 2/25/21 DTARC meeting. Ms. [redacted] would like the following to be considered: 1) she wants her UR approved urology consult, 2) she would like to have an endocrinologist appointment since she has not had one in eight months, and 3) she would like to be considered for compassionate release or ECL. Ms. [redacted] stated thoughts of self-mutilation are sometimes on her mind due to her gender dysphoria and not receiving her urology consult despite DTARC and UR approval. She expressed worry because she feels she is increasingly impulsive and her coping mechanisms have not been helping. Therapy focused on examining how the current generation is changing how transgender/non-binary issues are being addressed as to body image. Ms. [redacted] acknowledged that some transgender individuals she has met are not as focused on changing their physical characteristics and stated "I think I tried that but I don't think it's possible."

Ms. [redacted]t indicated her Zoloft did not seem to be working as well, and the undersigned indicated she would ask Mr. Messer about psychiatry clinic. The referral process was also discussed, especially given her concern that she has been "super-impulsive" lately. Ms. [redacted] and the undersigned briefly discussed the idea of trying to meet with the offender regarding the incident but it was decided that was not a good idea because the woman may have contacted lawyers.

Plan/Diagnostic Changes

Ms. [redacted] has improved since her NCCIW admission but continues to be dysphoric.

Follow-up/Next Appointment

Ms. [redacted] will be seen for her next individual therapy appointment in the next 30 to 45 days, if not sooner. She knows to submit a referral if she needs to be seen sooner.

Offender Name:	[redacted]			Off #:	0618705
Date of Birth:	[redacted]/1981	Sex:	F	Facility:	ANSO
Date:	02/19/2021 11:05	Provider:	Hahn, Patricia M Ph.D Asst. Dir.		

Co-Pay Required: No **Cosign Required:** No

Telephone/Verbal Order: No

Standing Order: No

Completed by Hahn, Patricia M Ph.D Asst. Dir. of Beh. Health on 02/19/2021 13:17

North Carolina Department of Public Safety
Mental Health Progress Note

Offender Name: [redacted] Off #: 0618705
Date of Birth: [redacted]1981 Sex: F Facility: ANSO
Date: 04/28/2021 10:30 Provider: Hahn, Patricia M Ph.D Asst. Dir.

Treatment Setting

Outpatient Program at Anson CI.

Reason for Services

Routine Follow-Up Session

Violence Alerts

Ms. [redacted] denied any current thoughts of wanting to harm others.

Escape Alerts

None currently noted.

Self-Injury Alerts

At the end of the session, Ms. [redacted] denied any current thoughts of wanting to harm herself. As a protest, however, at the beginning of the session she had a band tied around her penis because she had not yet had her urology appointment at UNC. During the session, the undersigned called Ms. Catlett to get an update, and Ms. Catlett has been working with UNC to get everything set up so that Ms. [redacted] can have her appointment. (It involves IT and getting credentialed to use WebEx so can take time.) Ms. [redacted] was satisfied with this response and asked to be excused to remove the band from her penis, which she said she did.

MSE/Behavioral Observations

Ms. [redacted] presented as a polite 39 year old Black-American female who appeared approximately her stated age. She was pleasant and cooperative during the therapy session. She displayed good eye contact and had no significant psychomotor agitation or retardation. Her speech was of normal rate, rhythm and volume. She was oriented to person, place, and time. Her attention and immediate memory appeared within normal limits. She appeared initially dysphoric but after hearing some progress was being made on her appointment, her affect brightened. At the end of the session she described her mood as "mediocre." She denied current suicidal (see above) or homicidal ideation. She did not currently show active symptoms of psychosis or a thought disorder. Her judgment and insight are slightly impaired.

Progress Towards Goal(s)

Ms. [redacted] expressed many concerns about not having her appointment with the UNC-CH urologist scheduled yet. She gave a number of examples of how this is increasing her dysphoria, and she decided to put a band on her penis until her appointment is scheduled. She said she has had the band on for a week and a half. She was cautioned about the effects of impeding blood flow and risk of infection. As described above, the undersigned spoke with Ms. Catlett, and she was able to convey to Ms. [redacted] how Ms. Catlett has been on top of it and has worked hard to facilitate this appointment. Ms. [redacted] then agreed to take the band off her penis.

The rest of the session addressed her specific concerns about having part of a penis left and what defines a woman. She explained it does not bother her if she is called fat or ugly but stated if she is called a man "there is no tool in the [psychology] toolbox to manage that." She stated "I can't live with this any more," and said the situation was acute now and not chronic. She also stated she is not complete now and that "I'm ready to be complete."

Plan/Diagnostic Changes

Ms. [redacted] has increased dysphoric mood but her mood improved when she was provided information that she should have her appointment with the Program Manager of the UNC Transgender Health Program within the next week or the week after. The undersigned will follow-up next Thursday on the progress of this appointment.

Follow-up/Next Appointment

Ms. [redacted] will be seen for her next individual therapy appointment in the next 30 to 45 days. She knows to submit a referral if she needs to be seen by an Anson facility psychologist before then.

Co-Pay Required: No **Cosign Required:** No

Telephone/Verbal Order: No

Offender Name:	[redacted]	Off #:	0618705
Date of Birth:	[redacted]/1981	Sex:	F
Date:	04/28/2021 10:30	Provider:	Hahn, Patricia M Ph.D Asst. Dir.

Standing Order: No

Completed by Hahn, Patricia M Ph.D Asst. Dir. of Beh. Health on 04/28/2021 12:29

North Carolina Department of Public Safety
Mental Health Progress Note

Offender Name: [redacted] Off #: 0618705
Date of Birth: [redacted]1981 Sex: F Facility: ANSO
Date: 09/16/2021 14:10 Provider: O'Halloran, Maureen C MSW

Treatment Setting

Outpatient Program at Anson CI; Offender [redacted] will be referred to as Ms. Brown in the remainder of this document.

Reason for Services

Crisis Intervention

Violence Alerts

There are no elevated risk factors presently noted for offender Brown.

Escape Alerts

There are no elevated risk factors presently noted for offender Brown.

Self-Injury Alerts

Ms. Brown currently denied suicidal ideation and thoughts of self-injurious behavior, both intent and plan.

MSE/Behavioral Observations

Ms. Brown's mood appeared mildly dysphoric, and her affect was appropriate to content. She was neatly groomed, wearing prison-issued attire, makeup, and a face mask. She was tearful when discussing news that she had been denied gender-affirming surgery. She made comfortable eye contact. Her speech was relevant and goal directed. Her psychomotor activity was somewhat elevated. There was no overt evidence of psychotic or delusional thought processes. Her judgment and impulse control appeared adequate at this time. Ms. Brown voiced complaints regarding feeling emotionally overwhelmed. She appeared to be undergoing situational distress today regarding her medical treatment.

Progress Towards Goal(s)

Progress was not assessed as this was the first encounter with the offender. Ms. Brown reported that she learned that she was denied surgery earlier this week. She stated that she felt emotionally overwhelmed as she has been advocating for this procedure for four years now. She discussed losing weight in order to meet criteria for the procedure. Supportive psychotherapy was provided as Ms. Brown discussed her frustrations and concerns. She denied any suicidal thoughts, plans, or intent. She admitted that she had briefly considered putting a rubber band around her phallus as a means of forcing surgical intervention. The writer explained that Ms. Brown would only undermine her chances for gender-affirming surgery if she was considered to be emotionally unstable for treatment. She acknowledged understanding.

She also reported that she has been eating approximately 700 calories per day and drinking 10 20-ounce bottles of water per day. We discussed a more balanced approach to meeting her nutritional needs. She was open to the writer's suggestions, and reported she would work on eating more. She appeared calmer by the session's conclusion.

Plan/Diagnostic Changes

There are no changes to report at this time. Continue treatment as specified.

Follow-up/Next Appointment

Follow up as previously scheduled with primary therapist.

Co-Pay Required: No **Cosign Required:** No
Telephone/Verbal Order: No
Standing Order: No

Completed by O'Halloran, Maureen C MSW Clinical Social Worker on 09/16/2021 15:40

North Carolina Department of Public Safety
Psychiatric Progress Note

Offender Name: [redacted] Off #: 0618705
Date of Birth: [redacted]/1981 Sex: F Facility: ANSO
Date: 10/27/2021 09:16 Provider: Younus, Syeda R MD

Treatment Setting

Outpatient Program at Anson CI.

Violence Alerts

There is no apparent, current, significant risk of violence noted for inmate [redacted].

Self-Injury Alerts

There is no apparent, current, significant risk of self-injury noted for inmate [redacted].

However, SIRA was performed on 02/16/21.

Pt reports one suicide attempt in 2019 by OD "to get away from men prison."
She was admitted to inpatient NCCIW in December 2020 due to self harming thoughts.

Subjective

This is the 2nd incarceration for this 40 y.o. offender who was admitted to prison on 10/10/2017 on a primary charge of HABITUAL FELON with a project release date in 2024.

Pt was born biologically as a male but she identifies herself as female and going through transition of being female. She goes by Miss. Brown.

Pt was last seen by Dr. Younus in August, at that visit Zoloft dose was increased. Pt was seen today, she reports feeling stressed and overwhelmed. "I was told to lose weight then I can get my surgery but they denied it." She reports not able to focus as she is thinking about her surgery. She also feels that she is not getting the therapy which she needs. She wants "therapist who has knowledge about transgender." She reports recently "I walked out of the office " during her therapy session. She feels Zoloft is helping her. She denies depression. She feels she is not getting adequate therapy. She sleeps good. She has lost weight.
She reports sometimes she thinks she may need to do "self mutilating" behavior to get help. She is upset that her surgery was denied.

No SI,HI, AVH or manic symptoms.

She is taking two classes.

She is married and her husband is supportive.

She has an adult son and she talks to him regularly. She has a grand child.

Pt has tried only Zoloft.

Objective

Identifying Information:40yrs old, biologically born as male but identified herself as female and is in the process of transitioning to a female
Appearance: fairly groomed, wearing mask
Behavior: cooperative

Thinking: Logical
Perception: Denies
Mood: "stressed"
Affect: appropriate
Orientation: no evidence of delirium or confusion
Suicidal/Homicidal Ideation: Patient denies both.
Judgment/Insight: fair

Side Effects

Denied.

Response to Treatment

Positive.

Labs/Weights/AIMS/Vitals

Reviewed.

Diagnosis

Gender Dysphoria
Unspecified Anxiety Disorder
Medical: [redacted]

Plan

Target Symptoms: Anxiety and mood.

Medications:
- Cont Zoloft Risk/benefits reviewed.
- Discussed Buspar, pt deferred it for now.

-She feels her current symptoms will get better with the help of "adequate" therapy, she was advised to monitor her symptoms and contact mental health if needed.
Referrals: Therapy(staff will notify via email). Encouraged to continue therapy .
Other Treatment/Labs: None
Follow-Up: 2-3 months or sooner as needed.

Renew Medication Orders:

Rx#	Medication	Order Date	Prescriber Order
A4530692	SERTRALINE 100 MG TAB	10/27/2021 09:16	Take two (2) tablets (=200mg) by mouth daily at 11am ** Direct Observation Therapy ** x 120 day(s) Pill Line Only

Indication: Gender Dysphoria in Adolescents and Adults, Unspecified Anxiety Disorder

Schedule:

Activity	Date Scheduled	Scheduled Provider
Psychiatric Progress Note f/u	01/19/2022 00:00	Younus, Syeda R Psychiatrist

Patient Education Topics:

Date Initiated	Format	Handout/Topic	Provider	Outcome
10/27/2021	Counseling	Compliance - Treatment	Younus, Syeda	Verbalizes Understanding
10/27/2021	Counseling	Medication Side Effects	Younus, Syeda	Verbalizes Understanding

Offender Name: [redacted] Off #: 0618705
Date of Birth: [redacted]1981 Sex: F Facility: ANSO
Date: 10/27/2021 09:16 Provider: Younus, Syeda R MD

Date Initiated	Format	Handout/Topic	Provider	Outcome
10/27/2021	Counseling	Access to Care	Younus, Syeda	Verbalizes Understanding

Co-Pay Required: No **Cosign Required:** No

Telephone/Verbal Order: No

Standing Order: No

Completed by Younus, Syeda R MD Psychiatrist on 10/27/2021 17:44

APPENDIX E

North Carolina Department of Public Safety
Clinical Encounter

Offender Name: [redacted]		Off #:	0618705
Date of Birth: [redacted]/1981	Sex: M Race: BLACK	Facility:	HARN
Encounter Date: 01/07/2019 09:03	Provider: Umesi, Joseph J MD	Unit:	GDM-

Provider Evaluation encounter performed at Clinic.

SUBJECTIVE:

COMPLAINT 1 **Provider:** Umesi, Joseph J MD

Chief Complaint: Other Problem

Subjective: Patient is a 37 year transgender female who started gender reassignment surgery prior to incarceration. Prior surgeries include bilateral orchiectomy, breast augmentation, facial feminization, Brazilian butt lift, forehead and chin fillers. Per Dr. Hope Sherrie, Cosmetic Concierge, the reassignment surgery was performed according to the guidelines of World Professional Association for Transgender Health Standards of Care. The next stage for patient prior to incarceration was full genital gender-affirming surgery. Patient is therefore requesting this surgery.

Patient is also working towards being transferred to a female camp. He is requesting female undergarment. According to patient, policy TX 1 through 13 subject evaluation and management for transgender offenders (section care of treatment for patients), requires accommodation including having female under garments if desired by patient.

Patient is requesting renewal of his medications. Patient's TARC (Transgender Accommodation Review Committee) meeting is scheduled for January 11, 2019.

Pain Location:
Pain Scale:
Pain Qualities:
History of Trauma:
Onset:
Duration:
Exacerbating Factors:
Relieving Factors:
Comments:

OBJECTIVE:

Temperature:

Date	Time	Fahrenheit	Celsius	Location	Provider
01/07/2019	08:59 HARN	98.4	36.9	Oral	Sansone, Kaneisia E RN

Pulse:

Date	Time	Rate Per Minute	Location	Rhythm	Provider
01/07/2019	08:59 HARN	75	Via Machine		Sansone, Kaneisia E RN

Respirations:

Date	Time	Rate Per Minute	Provider
01/07/2019	08:59 HARN	18	Sansone, Kaneisia E RN

Blood Pressure:

Date	Time	Value	Location	Position	Cuff Size	Provider
01/07/2019	08:59 HARN	110/77	Left Arm	Sitting	Adult-large	Sansone, Kaneisia E RN

SpO2:

Date	Time	Value(%)	Air	Provider

Date	Time	Value(%)	Air	Provider
01/07/2019	08:59 HARN	99	Room Air	Sansone, Kaneisia E RN

Height:

Date	Time	Inches	Cm	Provider
01/07/2019	08:59 HARN	70.0	177.8	Sansone, Kaneisia E RN

Weight:

Date	Time	Lbs	Kg	Waist Circum.	Provider
01/07/2019	08:59 HARN	255.0	115.7		Sansone, Kaneisia E RN

Exam:

General

Affect

Yes: Pleasant, Cooperative

Appearance

Yes: Apparent Distress

Head

General

Yes: Symmetry of Motor Function, Atraumatic/Normocephalic

Eyes

General

Yes: PERRLA, Extraocular Movements Intact

Periorbital/Orbital/Lids

Yes: Normal Appearing

Conjunctiva and Sclera

Yes: Normal Appearing

Neck

General

Yes: Supple, Symmetric, Trachea Midline

Thyroid

No: Diffuse Enlargement, Multinodular, Nodule, Tenderness

Musculoskeletal

Yes: Full ROM

No: Tenderness, Muscle Spasms, Trauma

Pulmonary

Auscultation

Yes: Clear to Auscultation

Cardiovascular

Auscultation

Yes: Regular Rate and Rhythm (RRR), Normal S1 and S2

No: M/R/G

Genitourinary

Previously evaluated and with presence of signs of reported surgeries.

Musculoskeletal

Wrist/Hand/Fingers

Yes: Normal Exam, Full Range of Motion

Ankle/Foot/Toes

Yes: Normal Exam, Full Range of Motion

Breast

Exam:

Female appearing breast. Did not perform brace exam.

Neurologic

Sensory And Motor Reflexes

Yes: Normal Exam

Cranial Nerves (CN)

Yes: CN 2-12 Intact Grossly

Motor System-General

Yes: Normal Exam

Mental Health

Patient is alert, oriented, cooperative, appropriate. Patient has no signs of higher cognitive deficits and appears confident and decisive as to what she wants to do.

ASSESSMENT:

Gender Dysphoria in Adolescents and Adults, 302.85 - Current, Chronic, Recurrence

PLAN:

Renew Medication Orders:

Rx#	Medication	Order Date	Prescriber Order
A3554227	ESTRADIOL 2 MG TAB	01/07/2019 09:03	Take one (1) tablet by mouth daily *UR approved until 1-20-19 x 180 day(s)
	Indication: Gender Dysphoria in Adolescents and Adults		
A3517861	CYANOCOBALAMIN 250 MCG TAB	01/07/2019 09:03	Take one (1) tablet by mouth daily x 365 day(s)
	Indication: Other fatigue		
A3517863	VITAMIN D3 1000 U TAB	01/07/2019 09:03	Take one (1) tablet by mouth daily x 365 day(s)
	Indication: Other fatigue		

New Laboratory Requests:

Details	Frequency	Due Date	Priority
Lab Tests-E-Estradiol Lab Tests-L-Luteinizing Hormone (LH) Lab Tests-T-Testosterone, Total	One Time	01/08/2019 00:00	Routine

New Consultation Requests:

Consultation/Procedure	Due Date	Priority	Translator	Language

UR Request	Routine (review within 30 days)	No

Reason for Request:

Full genital gender-affirming surgery. Patient started surgeries prior to incarceration. Prior surgeries include bilateral orchiectomy, breast augmentation, facial feminization, Brazilian butt lift, forehead and chin fillers. Per Dr. Hope Sherrie, Cosmetic Concierge, the reassignment surgery was performed according to the guidelines of World Professional Association for Transgender Health Standards of Care. The next stage for patient prior to incarceration was full genital gender-affirming surgery. Patient has TARC hearing 1/11/2019 and patient's endocrinology appointment has been scheduled. Patient has been followed by endocrinologist and mental health physician.

Provisional Diagnosis:

Transgender.

UR Request	Rush (review within 7 days)	No

Reason for Request:

Estradiol 2 mg daily x 6 months. Patient is transgender under care by endocrinologist who has approved continuing Estradiol which patient was on before incarceration.

Provisional Diagnosis:

Transgender.

UR Request	Rush (review within 7 days)	No

Reason for Request:

Five female undergarments every six months (size 8). Patient requesting this for accommodation following policy treatment 1 through 13, section care and treatment for patient, subject evaluation and management for transgender offenders.

Provisional Diagnosis:

Transgender.

Disposition:

Follow-up at Sick Call as Needed

Patient Education Topics:

Date Initiated	Format	Handout/Topic	Provider	Outcome
01/07/2019	Counseling	Plan of Care	Umesi, Joseph	Verbalizes Understanding

Co-Pay Required: No **Cosign Required:** No
Telephone/Verbal Order: No
Standing Order: No

Completed by Umesi, Joseph J MD on 01/07/2019 09:47

UNC HEALTH

UNCH
500 Eastowne Drive
Chapel Hill NC 27514-2244

[redacted]
MRN: 000015493026, DOB: [redacted]1981, Sex: F
Visit date: 7/12/2021

Kindsey Lyn, RN

07/12/2021 - Office Visit in UNCH UROLOGY HILLSBOROUGH

Abstract Notes

Progress Notes

Bradley David Figler, MD at 7/12/2021 1100

Author: Bradley David Figler, MD | Service: — | Author Type: Physician
Filed: 07/18/21 0652 | Encounter Date: 7/12/2021 | Status: Signed
Editor: Bradley David Figler, MD (Physician)

ASSESSMENT:
Transgender adult, interested in vaginoplasty

DISCUSSION:

We had an extensive discussion re: vaginoplasty.

We discussed indications for the procedures. She is aware that we follow the World Professional Association for Transgender Health (WPATH) standards of care (SOC), and has access to the latest standards of care. Criteria for genital surgery, according to WPATH SOC:

- Pesistent, well documented gender dysphoria
- Capacity to make fully informed decisions and to consent to treatment
- Age of majority in a given country
- If significant medical or mental health concerns are present, they must be well controlled
- 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unwilling or unable to take hormones)
- 12 continuous months of living in a gender role that is congruent with their gender identity
- Two referrals, at least one from a qualified mental health professional

We discussed rationale for referrals. The purpose of these assessment letters is to assess emotional stability and confirm these three primary categories:

- Presence of persistent gender dysphoria
- If any mental health issues are present, they are reasonably well controlled
- Someone has lived in their identified gender for at least one year.

We discussed penile inversion vaginoplasty in detail, including our technique, pre-operative and post-operative management. We discussed peri-operative hormone management, and I requested that she consult with her hormone provider re: peri-operative dosing.

We discussed risks of the procedure. General risks of the procedure include heart attack, stroke, pneumonia, blood clots, pulmonary embolus, and others. Estrogen has been associated with venous thromboembolism through multiple mechanisms, though there is considerable variability in practice patterns related to perioperative estrogen and there are currently no guidelines. Risks specific to the procedure include bleeding, tissue necrosis, wound dehiscence, poor cosmesis, pelvic pain, poor graft take, granulation tissue, neovaginal/labial hair, urge incontinence, stress incontinence, urethral stricture, post-void dribbling, urinary tract infections, weak, splayed and non-directable urine stream, adhesions, inability to orgasm or change in orgasm, pain/scarring, prolapse, vaginal stenosis/shortening, injury to surrounding tissue (including bowel, rectum, bladder, urethra) and possible development of fistula.

Because of the risk of neovaginal hair, we discussed the need for hair removed pre-operatively and we provided a template.

We discussed risks related to high lithotomy position, including lower extremity paresthesias or pain (the vast majority of which would resolve in 24 hours), compartment syndrome (requiring emergency surgery to decompress), and

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07/12/2021 - Office Visit in UNCH UROLOGY HILLSBOROUGH (continued)

Abstract Notes (continued)

rhabdomyolysis. These complications are more likely with longer times in the lithotomy position, and this surgery will require a prolonged lithotomy time.

We discussed importance of bolster and limited activity for graft take, and the importance of post-operative dilation and pelvic floor physical therapy.

We also discussed alternative approaches to vaginoplasty, including robotic peritoneal flap and bowel interposition.

A copy of "What You Need Before Vaginoplasty" from the UNC Transgender Health Program was provided.

After extensive discussion of risks, benefits and alternatives, decision was made to move forward with vaginoplasty.

PLAN:
- Proceed with **vulvoplasty** per WPATH criteria pending
  - Weight loss. Goal 215 (BMI 30), max 250 (BMI 35)
- Will order case request & notify surgery scheduler when approved by THP

HISTORY OF PRESENT ILLNESS:

A 39 y.o.-year-old transgender adult seen today in consultation at the request of Umesi, Joseph for bottom surgery.

Assigned male at birth
Pronouns: she/her
Living full time in current gender role since: 2012
On gender affirming hormones since: 2012
Hair removal: Face/chest only

Are you sexually active? No
Preferred gender of sexual partner(s)? Male
Do you use your penis for penetrative sex? No
Are you seeking a vaginal canal (vaginoplasty) or limited depth vulvoplasty? Vulvoplasty

Goals of surgery, ranked:
1. Dysphoria

PMH: [redacted]
PSH: Orchiectomy (hope sherry), brazilian butt lift, top surgery
Meds: Currently on transdermal estrogen 0.1mg biweekly for hormone therapy
Family Hx: No familial hx of bleeding or clotting disorders. No personal or family hx of DVT, PE.

Any tobacco use previous or current: No
IDU previous or current: No
Genital injury, surgery, UTIs, dysuria, hematuria, stricture, scrotal pain, elevated PSA, history of prostate biopsy, prostatitis, pelvic radiation: No
Circumcised: no
Children/interest in future fertility: No

UNC HEALTH

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07/12/2021 - Office Visit in UNCH UROLOGY HILLSBOROUGH (continued)

Abstract Notes (continued)

PMHX: [redacted]
No hx of clotting disorders in family

Height: 5'10 3/4"
Weight: (approx) 275lbs

I review history elements and review of systems on new patient intake form.

PAST MEDICAL HISTORY:

Past Medical History:

Diagnosis	Date
• Goiter	
• Male-to-female transgender person	
• Testosterone deficiency	
• Thyroid nodule *Left lobe complex nod*	07/27/2018

PAST SURGICAL HISTORY:

Past Surgical History:

Procedure	Laterality	Date
• BUNIONECTOMY		2018
• ORCHIECTOMY	Bilateral	
• TRANSUMBILICAL AUGMENTATION MAMMAPLASTY		10/2012

MEDICATIONS:

Current Outpatient Medications

Medication	Sig	Dispense	Refill
• [redacted]	Take 1 tablet by mouth daily.		
• estradioL (VIVELLE) 0.1 mg/24 hr	Place 1 patch on the skin Two (2) times a week.		
• sertraline (ZOLOFT) 100 MG tablet	Take 150 mg by mouth daily.		
• biotin 5 mg tablet	Take one tablet daily as directed by Dr. Pou Medically necessary for transition	90 tablet	1
• cholecalciferol, vitamin D3, (VITAMIN D3) 1,000 unit capsule	Take 1,000 Units by mouth daily.		
• cyanocobalamin (VITAMIN B-12) 100 MCG tablet	Take 250 mcg by mouth daily.		
• MINERAL OIL-	Apply 120 g topically		

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07/12/2021 - Office Visit in UNCH UROLOGY HILLSBOROUGH (continued)

Abstract Notes (continued)

PETROLAT,WHT-WATER TOP every thirty (30) days.

No current facility-administered medications for this visit.

ALLERGIES:
No Known Allergies

FAMILY HISTORY:
Family History

Problem	Relation	Age of Onset
• Cancer	Mother	

SOCIAL HISTORY:
Social History

Socioeconomic History

• Marital status:	Single
Spouse name:	Not on file
• Number of children:	Not on file
• Years of education:	Not on file
• Highest education level:	Not on file

Occupational History
- Not on file

Tobacco Use

• Smoking status:	Never Smoker
• Smokeless tobacco:	Never Used

Substance and Sexual Activity

• Alcohol use:	No
• Drug use:	Not on file
• Sexual activity:	Not on file

Other Topics Concern
- Not on file

Social History Narrative
- Not on file

Social Determinants of Health

Financial Resource Strain
- Difficulty of Paying Living Expenses:

Food Insecurity
- Worried About Running Out of Food in the Last Year:
- Ran Out of Food in the Last Year:

Transportation Needs
- Lack of Transportation (Medical):
- Lack of Transportation (Non-Medical):

Physical Activity

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07/12/2021 - Office Visit in UNCH UROLOGY HILLSBOROUGH (continued)

Abstract Notes (continued)

- Days of Exercise per Week:
- Minutes of Exercise per Session:

Stress:
- Feeling of Stress :

Social Connections:
- Frequency of Communication with Friends and Family:
- Frequency of Social Gatherings with Friends and Family:
- Attends Religious Services:
- Active Member of Clubs or Organizations:
- Attends Club or Organization Meetings:
- Marital Status:

REVIEW OF SYSTEMS:
10-system review of systems negative other than what is mentioned above.
The patient was asked to review all abnormal responses not pertinent to today's visit with their primary care physician.

PHYSICAL EXAM:
GENERAL: Pleasant adult in no acute distress.
VITAL SIGNS: Blood pressure 125/85, pulse 62, temperature 36.4 °C (97.6 °F), temperature source Temporal, resp. rate 18, height 180.3 cm (5' 11"), weight(!) 130.6 kg (288 lb), SpO2 100 %.
Estimated body mass index is 40.17 kg/m² as calculated from the following:
Height as of this encounter: 180.3 cm (5' 11").
Weight as of this encounter: 130.6 kg (288 lb).
HEENT: Normocephalic, atraumatic, extraocular muscles intact
NECK: Supple, no lymphadenopathy
CARDIOVASCULAR: No peripheral edema
PULMONARY: Normal work of breathing, no use of accessory muscles
ABDOMEN: Soft, non-tender, non-distended. No organomegaly or hernias.
BACK: No costovertebral angle tenderness, no spiny bone tenderness.
EXTREMITIES: No clubbing, cyanosis or edema.
NEUROLOGIC: Cranial nerves II-XII grossly intact
PSYCHOLOGIC: Normal affect, normal mood
SKIN: Warm and dry. No lesions.
GU: nl non-circ phallus
Penis size: Adequate
Scrotal size: Adequate

LAB RESULTS:
Results for orders placed or performed in visit on 03/06/20
TSH

Result	Value	Ref Range
TSH	0.907	0.600 - 3.300 uIU/mL

Estradiol (Estrogen) Level

Result	Value	Ref Range
Estradiol	277.4	pg/mL

Luteinizing hormone

Result	Value	Ref Range

UNC HEALTH

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Visit date: 7/12/2021

07/12/2021 - Office Visit in UNCH UROLOGY HILLSBOROUGH (continued)

Abstract Notes (continued)

LH	6.8	mIU/mL

Vitamin B12 Level

Result	Value	Ref Range
Vitamin B-12	653	193 - 900 pg/ml

Vitamin D 25 Hydroxy (25OH D2 + D3)

Result	Value	Ref Range
Vitamin D Total (25OH)	26.5	20.0 - 80.0 ng/mL

Ordered at this visit: No orders of the defined types were placed in this encounter.

No results found for: PSASCRN, PSADIAG

Lab Results

Component	Value	Date
WBC	6.8	10/17/2012
HGB	14.7	10/17/2012
HCT	44.8	10/17/2012
PLT	308	10/17/2012

Lab Results

Component	Value	Date
NA	138	12/02/2019
K	4.1	12/02/2019
CL	102	12/02/2019
CO2	27.0	12/02/2019
BUN	20	12/02/2019
CREATININE	1.12	12/02/2019
GLU	89	12/02/2019
CALCIUM	9.4	12/02/2019

Lab Results

Component	Value	Date
BILITOT	0.6	12/02/2019
BILIDIR	0.20	12/02/2019
PROT	7.6	12/02/2019
ALBUMIN	4.3	12/02/2019
ALT	17	12/02/2019
AST	28	12/02/2019
ALKPHOS	66	12/02/2019

No results found for: LABPROT, INR, APTT

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MRN: 000015493026, DOB: [redacted]/1981, Sex: F
Visit date: 7/12/2021

Abstract Notes (continued)

Electronically signed by Bradley David Figler, MD at 07/18/21 0652

End of Document

North Carolina Department of Public Safety
Transgender Accommodation Summary

Offender Name:	[redacted]			Off #:	0618705
Date of Birth:	[redacted]/1981	Sex:	F	Facility:	ANSO
Date:	10/20/2021 09:00	Provider:	Dula, Jennifer L MSW Clinical		

Review of Mental Health History

Ms. Brown is a transgender female receiving mental health services while currently housed at Anson Correctional Institution for Women. She has actively engaged with mental health services since October 2017.

Prior to incarceration, Ms. Brown endorses engaging in mental health services as part of the requirements for trans-affirming medical care such as cross-hormonal therapy and various gender-affirming surgical interventions. Specifically, Ms. Brown reports engaging in eight months of psychotherapy in 2012 prior to initiating gender-affirming medical procedures and care. She denies engaging in any other mental health services outside of addressing her gender dysphoria.

Since incarceration, Ms. Brown has engaged in mental health services to access transgender accommodations and to address and manage her feelings of gender dysphoria and the subsequent anxiety and depression associated with it. Review of the records shows mostly routine psychotherapy and treatment in support of her transitional care. There has been some crisis intervention required including four SIRA's and one in-patient placement since 2017. The acute events have been connected to Ms. Brown's distress over her gender identity and the process of addressing her transitional needs within a multi-level medical system.

Accommodation Requests

Ms. Brown expresses a persistent desire for trans-feminine bottom surgery. After consulting with outside medical providers at UNC Trans Health, Ms. Brown determined vulvoplasty was the next step in her transitional care. Her goals of surgery are to alleviate her gender dysphoria. She wants to feel comfortable in her own body and feel that it matches who she is on the inside. She feels others will see her as the woman she knows herself to be which will reduce her anxiety and depressive symptoms.

Review of Transgender History

Ms. Brown identifies as a transgender female and uses female pronouns (she, her hers). Ms. Brown endorses feelings of gender incongruence since the age of around the age 7 or 8 years old. She began the process to socially transition in 2011. She has changed pronouns, legally changed her name, engages in tucking and is currently housed in a female facility. She has been successfully living in a gender role congruent with her affirmed gender since at least 2014. She has been consistently on hormone therapy since 2012. Ms. Brown has also undergone several other gender affirming surgeries as part of her transition such as an orchiectomy, breast augmentation and facial feminization.

Despite these interventions, Ms. Brown continues to report clinically significant anxiety, depression and distress associated with her gender dysphoria that has been documented consistently throughout her mental health treatment. My clinical evaluation and the existing mental health documentation for Ms. Brown meets the criteria for a diagnosis of Gender Dysphoria.

Based on the review of her records and the current assessment, it appears the next appropriate step for Ms. Brown is to undergo trans-feminine bottom surgery. The surgery will help her make significant progress in further treatment of her gender dysphoria. Ms. Brown is psychologically stable to undergo this surgery and will be able to access post op care at an appropriate DPS facility. She has no issues with illicit drug use or abuse. Review of the all medical consultations with UNC Trans Health show that the risks, benefits and alternatives of this surgery have been reviewed with Ms. Brown, and she showed an excellent understanding during those consultations and this evaluation. She has demonstrated the ability to make an informed decision about undertaking surgery. In summary, Ms. Brown has met the WPATH criteria and is an appropriate candidate for surgery.

Adjustment to Incarceration

Ms. Brown has struggled at times with being incarcerated as a transgender female. Her adjustment has improved since being transferred to a female facility. For the most part, the other inmates and staff have been inclusive and supportive. However, now that the issue of housing has been addressed and is affirming, it seems to have made her more aware and dysphoric about the one part of her body that does not affirm her gender identity. Ms. Brown demonstrates a desire to use her coping strategies but is expressing increased frustration with the process.

Offender Name:	[redacted]	Off #:	0618705
Date of Birth:	[redacted]/1981	Sex:	F
Date:	10/20/2021 09:00	Provider:	Dula, Jennifer L MSW Clinical

Co-Pay Required: No **Cosign Required:** No

Telephone/Verbal Order: No

Standing Order: No

Completed by Dula, Jennifer L MSW Clinical Social Worker on 10/26/2021 11:55

North Carolina Department of Public Safety
Clinical Encounter

Offender Name: [redacted]				Off #:	0618705
Date of Birth: [redacted]/1981	Sex:	F	Race: BLACK/AFRI	Facility:	ANSO
Encounter Date: 10/21/2021 08:24	Provider:	Caraccio, Donald MD		Unit:	LPODE

Endocrinology encounter performed at Telehealth.

SUBJECTIVE:

COMPLAINT **1** Provider: Caraccio, Donald MD

Chief Complaint: Other Problem

Subjective: This is 40yo transgender woman seen for continued hormonal treatment. She is s/p orchiectomy and has been on estrogen since 2012. She is seeking vulvoplasty as part of her treatment of Gender dysphoria (DSM V diagnosis).

Tolerating estradiol 20mg Q 14 days. She is now at 245lbs (from ~275lbs). She saw Dr. Figler and was cleared from him for surgery (vulvoplasty) is she could get weight to under 250lbs. She was then denied by prison. She is working with ACLU on this.

Hair growth is less. Having less frequent erections, which has had a very big impact on her mental health status. No leg swelling. No chest pain/SOB. Her mood is excellent.

Her first estradiol measurement was 309 on day 13 after injection. Her next level was 1082 on day 8.

Pain Location:

Pain Scale:

Pain Qualities:

History of Trauma:

Onset:

Duration:

Exacerbating Factors:

Relieving Factors:

Comments:

OBJECTIVE:

Temperature:

Date	Time	Fahrenheit	Celsius	Location	Provider
10/16/2021	14:23 ANSO	98.3	36.8	Oral	Crump, Alison F LPN

Pulse:

Date	Time	Rate Per Minute	Location	Rhythm	Provider
10/16/2021	14:23 ANSO	76	Via Machine		Crump, Alison F LPN

Respirations:

Date	Time	Rate Per Minute	Provider
10/16/2021	14:23 ANSO	18	Crump, Alison F LPN

Blood Pressure:

Date	Time	Value	Location	Position	Cuff Size	Provider
10/16/2021	14:23 ANSO	114/77	Left Arm	Sitting	Adult-large	Crump, Alison F LPN

SpO2:

Date	Time	Value(%)	Air	Provider
10/16/2021	14:23 ANSO	100	Room Air	Crump, Alison F LPN

Height:

Date	Time	Inches	Cm	Provider
10/16/2021	14:23 ANSO	71.0	180.3	Crump, Alison F LPN

Weight:

Date	Time	Lbs	Kg	Waist Circum.	Provider
10/16/2021	14:23 ANSO	240.8	109.2		Crump, Alison F LPN

Exam:

General

Appearance

Yes: Appears Well

No: Apparent Distress

Nutrition

Yes: Normal, Excellent food intake

Pulmonary

Observation/Inspection

Yes: Normal

Cardiovascular

Observation

No: Painful Distress

Abdomen

Inspection

Yes: Normal

Significant reduction in central obesity

Mental Health

Mood

Yes: Normal

Thought Process

Yes: Normal

ASSESSMENT:

Gender Dysphoria in Adolescents and Adults, 302.85 - Current, Chronic, Marked Improvement - *Patient responding well to IM estradiol. Her levels are above goal (mid cycle 200-350pg/ml).*

Plan: reduce to 10mg estradiol IM every 14 days.

Check estradiol level on day 7 after injection in December. Also check fasting lipid panel and hepatic function panel.

We discussed perioperative hormone reduction. There is no established guidelines in this area. Given her age and obesity, she has some risks for VTE. Given that she is on a hormone replacement with longer duration of action, I would recommend holding any estradiol injections two weeks prior to surgery and restarting and standard dose one week after surgery.

Did review recent literature on this "Effect of cross-sex hormone therapy on VTE risk in M-F gender affirming surgery" Annals of Plastic Surgery 1/2021.

Regarding for desire for vulvaplasty, this is medically necessary part of treatment for this patient. She has been treated with hormones since 2012 and orchiectomy in 2017, with persistent symptoms of gender dysphoria. Will communicate my plans with Dr. Figler.

PLAN:

Schedule:

Activity	Date Scheduled	Scheduled Provider
Provider Clinic	10/21/2021 00:00	Physician

follow up 2 months (around 12/21) with caraccio telehealth endo for transgender

Disposition:

General Population

Patient Education Topics:

Date Initiated	Format	Handout/Topic	Provider	Outcome
10/21/2021	Counseling	Access to Care	Caraccio, Donald	Verbalizes Understanding

Co-Pay Required: No **Cosign Required:** No

Telephone/Verbal Order: No

Standing Order: No

Completed by Caraccio, Donald MD on 10/21/2021 09:35

Requested to be reviewed by Norris, Jennifer L. NP.

Review documentation will be displayed on the following page.

North Carolina Department of Public Safety
Cosign/Review

Offender Name:	[redacted]			Off #:	0618705
Date of Birth:	[redacted]/1981	Sex:	F	Race:	BLACK/AFRIC
Encounter Date:	10/21/2021 08:24	Provider:	Caraccio, Donald MD	Facility:	ANSO

Reviewed with New Encounter Note by Norris, Jennifer L. NP on 10/21/2021 13:08.

APPENDIX F

NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY
Facility Transgender Accommodation Review Committee (TARC) Report

Offender Name: [redacted] OPUS Number: 0618705

Facility at Time of TARC: Harnett 3805 Date of TARC: 1/11/19

Name and Title of TARC Members Present: Melanie Shelton ASP, Marshall Pike ASC, Dr. Hahn Assistant Director of MH, Mrs. Hendricks PA, Tammy Black Nursing Supervisor, Cpt. Gutierrez PREA Compliance Manager, Patience Thomas Social Worker, Megan Deloatch Staff Psychologist, Jessica Laub Staff Psychologist.

Offender Present: X Yes ____ No

Related medical evaluations completed (specify if not applicable, otherwise list date and provider for each): 1/7/19: Provider Evaluation For Gender Dysphoria in Adolescents and Adults, Dr. Joseph Umesi

Related mental health evaluations completed (specify if not applicable, otherwise list date and provider for each): 10/13/17: MHA, Susan Garvey MA LPA, 12/18/18: Administrative Gender ID Committee Report, Dr. Brumbaugh

Transgender accommodations requested (specify if none were requested, otherwise list requests): Gender reassignment surgery, to be housed at female facility, women's undergarments, name change in HERO, transfer to another facility (Warren CI), housing closet to officers desk, private showers, bras

Routine Accommodations (per policy):

Approved: Continued hormone treatment, bras, private shower, housing closest to officer's desk, inmate is currently backlogged for Warren CI, inmate informed name changes cannot be completed due to the operating system not allowing it

Not Approved and Rationale: 1) Female undergarments due to safety and security concerns which could put the inmate at risk for being targeted by sexual deviants of which HCI has a larger concentration than most facilities.

Non-Routine Accommodations for Division TARC Review (per policy):

Recommended:

Not Recommended and Rationale: Gender reassignment, housing at female facility (offender still has intact penis with no testicles),

Scan into HERO as "TARC/Facility Report."
Attach to HERO Scanned Document Type "Facility Transgender Accommodation Committee Report."

DC - 411F (07/18) This form is not to be amended, revised, or altered without approval of the Medical Records Committee.

NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY
Division Transgender Accommodation Review Committee (TARC) Report

Offender Name: [redacted] OPUS Number: 0618705

Facility TARC Date: 7/11/2019 Division TARC Date: August 21, 2019

Names and Titles of TARC Members Present: Anita Wilson, Medical Director; Charlotte Williams, PREA Director; Gary Junker, Director of Behavioral Health; Anita Myers, Director of Nursing; Sarah Cobb, Deputy Director Rosemary Jackson, UR physician; Terri Catlett, Director of Administration

Transgender Accommodation Requests Under Review:

Request vaginoplasty

Approved Accommodations:

Accommodations Not Approved and Rationale:

Request for vaginoplasty - Deferred as offender has successfully completed gender reassignment surgically. Vaginoplasty is an elective procedure which is not medically necessary for reassignment. Current staffing and resources does not allow for the proper post operative care of this procedure

Other:

Scan into HERO as "TARC/Division Report."
Attach to HERO Scanned Document Type "Division Transgender Accommodation Committee Report."

DC – 411D (07/18) This form is not to be amended, revised, or altered without approval of the Medical Records Committee.

NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY
Division Transgender Accommodation Review Committee (TARC) Report

Offender Name: [redacted] Kanautica Zayre-Brown OPUS Number: 0618705

Facility TARC Date: 2/7/2020 Division TARC Date: 5/21/2020

Names and Titles of TARC Members Present: Lewis Peiper (Interim Dir. BH), David Snell (Chief Medical Ofc), Brian Sheltman (Chief Psychiatrist), Rosemary Jackson (UR Physician), Valerie Langley (Interim Dir. Nursing), Josh Panter (Operations) Sara Cobb (Dir. Rehab. Services), Terri Catlett (Health Services Administration), Charlotte Williams (PREA Dir.)

Transgender Accommodation Request(s) Under Review: Gender affirmation surgery. Vaginoplasty.

Approved Accommodation(s):

Accommodation(s) Not Approved and Rationale: Determination on surgery pending in-person consultation with surgical specialist.

Accommodation(s) Referred for Final Determination: DTARC recommends an in-person consultation with an OBGYN surgical specialist with experience in gender affirmation surgery.

Other:

Final Determination of Referred Accommodation(s)

This case was reviewed by G. Junker, Director of Health and Wellness and B. Harris, Asst. Commissioner of Prisons per policy. After review of the record, we concur with the DTARC to not approve the requested accommodation. After an in-person consultation with an OBGYN surgical specialist with experience in gender affirmation surgery occurs, the DTARC is directed to review consultation results to reconsider the request for accommodation to include rationale that any proposed surgery is supported as medically necessary.

Scan Type: "TARC/Division Report."
Attach: "Division Transgender Accommodation Committee Report."

This form is not to be amended, revised, or altered without approval of the Behavioral Health Documentation Committee.
DC – 411D (05/20)

NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY
Division Transgender Accommodation Review Committee (TARC) Report

Offender Name: [redacted] (Kanautica Zayre-Brown) OPUS Number: 0618705

Facility TARC Date: _____ Division TARC Date: 2/25/2021

Names and Titles of TARC Members Present: Lewis Peiper (Dir. of BH), Arthur Campbell (Chief Med. Ofc.), Brian Sheitman (Chief Psychiatrist), Valerie Langley (Dir. of Nursing), Terri Catlett (Dir. Health Serv. Admin), Charlotte Williams (PREA Director), Josh Panter (Dir. Operations), Sarah Cobb (Dir. Rehab. Services), Cynthia Bostic (Asst. Dir. Rehab. Services)

Transgender Accommodation Request(s) Under Review: In-person consultation with UNC surgical specialist

Approved Accommodation(s): Attempts to schedule in-person consultation with UNC Urology had been unsuccessful. Ms. Catlett provided a follow-up in an effort to get appointment scheduled. The appointment would be informational for both the offender and prison system. The information would then be reviewed by DTARC for further consideration.

Accommodation(s) Not Approved and Rationale: _____

Accommodation(s) Referred for Final Determination: _____

Other: Ms. Catlett was informed prior to the offender being seen by a Specialist for an in-person appointment, offender will need to meet with the UNC Transgender Health Program Management Team. Ms. Catlett has requested additional details of what the meeting with the UNC Transgender Program Management Team would entail.

Final Determination of Referred Accommodation(s)

Scan Type: "TARC/Division Report."
Attach: "Division Transgender Accommodation Committee Report."

This form is not to be amended, revised, or altered without approval of the Behavioral Health Documentation Committee.
DC – 411D (05/20)

COMMENTS: HAIR LOSS IS TO BE TREATED, SHOULD ENDOCRINOLOGY BE CONSULTED? LJ
MALE PATTERN BALDNESS IS CONSIDERED PRIMARILY COSMETIC.

UR REQUEST DATE: 08/18/21 TIME: 09:01 LOCATION: 4575 -ANSON CI
UR REQUEST TYPE: C-RUSH 02-PROCEDURE
UR REQUEST BY : MD/DDS/DO: NJL18-NORRIS,JENNIFER LEIGH
NURSE : HDL68-HILDRETH, DELOISE LISA
DIAGNOSIS/COMPLAINT: F64.9 -GENDER IDENTITY DISORDER UNS
CPT/HCPCS/VE REQ. : 57291 -CONSTRUCTION OF VAGINA
PROVIDER REQUESTED : UNC16-UNC PHYS/NON-CONTRAC AT G1680 UNC HOSPITALS
DRUG REQUESTED : EMER/CO-PAY EXEMPT?

ACTION : 08/18/21 09:48 BY DAF03-CAMERON, ALICE L. ACTION:CARE/PENDED
REASON(S) EVL - FURTHER EVALUATION
PENDED TO: AEX06- AMOS, ELTON
AUTHORIZATION NO. EXPIRATION DATE :
LENGTH OF STAY : DAYS TOTAL APPROVED: DAYS
BEGIN DATE/TIME : AT
STOP PAYMENT DATE: ACTUAL DISCHARGE DATE :

ACTION : 09/08/21 14:54 BY AEX06-AMOS, ELTON ACTION:CARE/DEFERRED
REASON(S) GNM - GUIDELINES NOT MET
PENDED TO: UNIT - UNIT UR NURSE
AUTHORIZATION NO. EXPIRATION DATE :
LENGTH OF STAY : DAYS TOTAL APPROVED: DAYS
BEGIN DATE/TIME : AT
STOP PAYMENT DATE: ACTUAL DISCHARGE DATE :

COMMENTS: RECORDS FROM UNC UROLOGY REVIEWED. RECOMMENDATIONS FOR VULVOPLASTY. PATIENT WITH 40 POUND WEIGHT LOSS IN 3 MONTHS AND A BMI OF 36.4. REQUEST UR APPROVAL FOR SURGERY.
9.8.21 ELECTIVE PROCEDURES NOT APPROVED. EA

UR REQUEST DATE: 10/22/21 TIME: 08:00 LOCATION: 4575 -ANSON CI
UR REQUEST TYPE: D-ROUTINE 01-CONSULT
UR REQUEST BY : MD/DDS/DO: NJL18-NORRIS,JENNIFER LEIGH
NURSE : HDL68-HILDRETH, DELOISE LISA
DIAGNOSIS/COMPLAINT: F64.9 -GENDER IDENTITY DISORDER UNS
CPT/HCPCS/VE REQ. : UNLIS -UNLISTED CONSULT
PROVIDER REQUESTED : TEND2-TH ENDO-CARACCIO AT 4575 ANSON CI
DRUG REQUESTED : EMER/CO-PAY EXEMPT?

NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY
Division Transgender Accommodation Review Committee (TARC) Report

Offender Name: [redacted] (Kanautica Zayre-Brown) OPUS Number: 0618705

Facility TARC Date: review by DTARC Division TARC Date: 2/17/2022

Names and Titles of TARC Members Present: Dr. Lewis Peiper, Behavioral Health Director; Dr. Arthur Campbell, Chief Medical Officer; Dr. Brian Sheitman, Chief of Psychiatry; Terri Catlett, Dir. Health Services Admin; Charlotte Williams, PREA Director; Sarah Cobb, Dir. Rehabilitative Srvcs; Josh Panter, Director of Operations

Transgender Accommodation Request(s) Under Review: Gender Affirmation Surgery/ Vulvaplasty

Approved Accommodation(s):

Accommodation(s) Not Approved and Rationale:

Accommodation(s) Referred for Final Determination: DTARC does not recommend Gender Affirmation surgery. This surgery is not medically necessary.

Other:

Final Determination of Referred Accommodation(s)

The Deputy Commissioner and Director of Health and Wellness reviewed documents related to this accommodation request. After review and discussion we concur with the DTARC recommendation. The ~~requested accommodation is not supported.~~

Scan Type: "TARC/Division Report."
Attach: "Division Transgender Accommodation Committee Report."

This form is not to be amended, revised, or altered without approval of the Behavioral Health Documentation Committee.
DC – 411D (05/20)

North Carolina Department of Public Safety
Division Transgender Accommodation Committee Report

Offender Name:	[redacted]			Off #:	0618705
Date of Birth:	[redacted]1981	Sex:	F	Facility:	ANSO
Date:	04/26/2022 12:00	Provider:	Peiper, Lewis J Ph.D Dir. of		

Comment

The following note is a summary of related input and considerations from the 2/17/2022 Division Transgender Acommadation Review Committee and concludes with a medical analysis from the Division of Prisons Medical Authority related to [redacted] (Kanautica Zayre-Brown, 0618705), referred to as Offender Brown and/or patient below with she/her pronouns used where applicable.

Offender Brown was admitted to prison 10/10/2017 with a current projected release date of 11/2/2024. She is currently housed at Anson CI where she was transferred from Warren CI on 8/15/02019. Offender Brown is currently assigned to Medium Custody after being promoted from Close Custody on 1/4/2022.

In response to Offender Brown's request for vaginoplasty or vulvoplasty surgery, the DTARC recommended receiving a consult from a surgical specialist experienced in performing vaginoplasty surgeries to obtain information to further evaluate treatment options and proposed course going forward. Offender Brown participated in a telehealth appointment with Kristia Vasilof from the UNC Transhealth Program as part of the initial review for consult and Katherine Croft (UNC Transhealth Program Manager) completed a telehealth consult with Offender Brown as part of the planned surgical consult with the UNC Transhealth program. An in-person consultation with Dr. Figler from the UNC Transhealth Program on 7/12/2021 indicated the patient's desire for vulvoplasty (versus vaginoplasty) and the need for weight loss from the recorded weight of 288 at the time down to a maximum of 250 with an identified weight goal of 210.

DTARC Review 2/17/2022:
Offender Brown has maintained the minimum weight goal identified by the UNC Transhealth program. Weight has been below 240 since 11/15/2021 and at the time of the DTARC was most recently (2/11) at 236. Patient is now eligible for review related to DTARC recommendation on requested vulvoplasty surgery.

Review of patient's related mental health and behavioral health record, and the baseline criteria identified by UNC Transhealth Program could make her a candidate for surgery. The patient has a well-documented, persistent transgender identity with a desire for "bottom surgery." The patient has been educated on the surgical interventions by the UNC Transhealth Program and identified a preference for a vulvoplasty if performed. The patient had completed other gender-affirming surgeries (orchiectomy, breast implants) prior to incarceration and has been on hormone replacement therapy since 2012. Mental health and behavioral health case reviews indicated no current evidence of any significant comorbid mental health issues. Patient continues to demonstrate emotional and psychological stability with evidence of adequate coping skills. The patient's mood and anxiety symptoms appear well-controlled by psychiatric interventions, however, recent progress notes from supportive counseling and therapy sessions indicate the patient has been heavily focused on the status of the final decision regarding her requested/desired surgery and experiencing related anxiety/frustrated mood.

Offender Brown has been housed in a female prison since 8/2019 and her adjustment to being housed in a female prison has been generally acceptable apart from a period of time in the fall / winter of 2020 related to reports of this offender having engaged in assaultive and extortive behavior against female offenders. Although she has largely adapted well to her current facility assignment, continued vigilance is necessary in order to ensure the offender's continued stability and to protect other offenders.

MEDICAL ANALYSIS:
This offender has received and continues to receive extensive treatment while incarcerated. As with all treatments in medicine, ongoing re-evaluations are conducted and regimens adjusted based on the clinical course, with further interventions based on findings from those reevaluations.

Medical analysis for this case included a comprehensive review of the offender's medical and behavioral health history, as well as a comprehensive literature review. When treatments are considered for any patient, the most important imperative for physicians is to base recommendations on evidence-based medicine and consideration of that information in the context of the individual patient. Although the offender has clearly communicated a desire for further

gender-affirming surgery, there is insufficient medical evidence to indicate such a complex and irreversible surgical intervention is medically necessary for her at this time.

Based on this review, it is the determination of the medical authority that gender reassignment surgery (GRS) as requested by this offender is not medically necessary.

Co-Pay Required: No **Cosign Required:** No

Telephone/Verbal Order: No

Standing Order: No

Completed by Peiper, Lewis J Ph.D Dir. of Beh. Health on 04/26/2022 12:12

Requested to be reviewed by Dula, Jennifer L MSW Clinical Social Worker.

Review documentation will be displayed on the following page.

APPENDIX G

[redacted] [redacted] **(Kanautica Zayre-Brown, 0618705),** referred to as offender and/or patient below

- admitted to prison 10/10/2017
- current projected release date 11/2/2024
- Anson CI (transferred from Warren on 8/15/02019)
- Medium Custody (promoted from Close on 1/4/2022)

Surgery Request and Case Summary:

- 2/20/2020, DTARC recommended receiving a consult from a specialist experienced in performing vaginoplasty surgeries to obtain information to further evaluate treatment options and required course going forward.
- 8/4/2020, patient participated in telehealth appointment with Kristia Vasilof from UNC Transhealth Program as part of initial review for consult referral
- 8/27/2020, DTARC reviewed and recommended UR approval for in-person consult with UNC Transhealth Program
- 2/25/2021, DTARC reviewed information regarding need to meet with UNC Transhealth Program Manager prior to scheduling in-person appointment.
- 5/25/2021, Katherine Croft (Transhealth Program Manager) completed a telehealth consult with Offender Brown as part of the planned surgical consult with the UNC Transhealth program. The consult noted "no primary concerns were identified that would interfere with surgery except for weight, which the patient indicated she was intending to lose for surgery."
- 7/12/2021, patient was transported for an in-person consultation with Dr. Figler with the UNC Transhealth Program on 7/12/2021. The consultation documentation was received on 7/20/2021 at Anson and entered into the offender's document manager. The consultation indicated the patient's desire for vulvoplasty (not vaginoplasty) and need for weight loss from the recorded weight of 288 at the time down to a maximum of 250 with an identified weight goal of 210.
- 7/29/2021, Dr. Peiper informed by UNC Telehealth Program that they will need two referral letters related to WPATH criteria
- 10/4/2021, new updated Transgender Accommodation Summary completed as part of the referral letter requirement summarizing history of transition, patient's continued commitment to surgery, current and recent psychological stability, absence of uncontrolled comorbid mental health conditions, and that the patient met appropriate criteria for surgery.

DTARC Review 2/17/2022:

Patient has maintained the minimum weight goal identified by UNC Transhealth program. Weight has been below 240 since 11/15/2021 and at the time of the DTARC was most recently (2/11) at 236. Patient is now eligible for review related to DTARC recommendation on requested vulvoplasty surgery.

Mental health and behavioral health case reviews indicated no current evidence of any significant comorbid mental health issues. Review of patient's related mental health and behavioral health record indicates the criteria identified by UNC Transhealth Program for appropriateness for surgery have been met. The patient has a well-documented, persistent transgender identity with a commitment for "bottom surgery." The patient has been educated on the surgical interventions by the UNC Transhealth Program and identified a preference for a vulvoplasty if performed. The patient has lived as a female in the community prior to this incarceration and has been housed in a female prison since 8/2019. The

patient has completed other gender-affirming surgeries (orchiectomy, breast implants) and has been on hormone replacement therapy since 2012. The patient's mood and anxiety symptoms appear well-controlled by psychiatric interventions, however, recent progress notes from supportive counseling and therapy sessions indicate the patient has been heavily focused on the status of the final decision regarding her requested/desired surgery and experiencing related anxiety/frustrated mood.

MEDICAL ANALYSIS:

Medical analysis for this case included a comprehensive review of the offender's medical and behavioral health history, as well as a comprehensive literature review. When treatments are considered for any patient, the most important imperative for physicians is to base recommendations on evidence-based medicine and consideration of that information in the context of the individual patient.

Based on this review, it is the determination of medical authority that gender reassignment surgery (GRS) as requested by this offender is not medically necessary. The rationale for this determination is several fold, particularly when the requested treatment for this offender (vulvoplasty), is compared to what are considered "medically necessary" surgeries for other medical conditions.

First, medically necessary treatments, and this is particularly true of surgical procedures, consist of a single, or at most a very discrete subset of surgeries. This is entirely not the case in the context of GRS, where there are a wide range of treatments, most notably absent surgery, but also including surgeries, which are presented as "options" in treatment, and are largely determined by the patient's desires. This would not be the case were the procedure truly "necessary", defined as treatment required in order to protect life, to prevent significant disability, or to alleviate pain. In these cases, barring any individual contraindications to surgery, almost all individuals suffering with these symptoms would indeed consent to surgery. This is clearly not the case with GRS, as, according to NIH data (2019), only 25-35% of transgender individuals ever undergo any form of GCS. (Demographic and temporal trends in transgender identities and gender confirming surgery (nih.gov)). This would not be true of any other "medically necessary" procedure in this country.

Almost universally, medically necessary procedures are by definition covered by insurance carriers. This too is not the case with GRS. In fact, 64% (32 States) of U.S. States' Medicaid programs do not offer coverage for GRS. (Issue brief: Health insurance coverage for gender-affirming care of transgender patients (ama-assn.org)). In fact, in N.C. the State Employees Health Plan, as with the majority of other US State health plans similarly do not cover the cost of GCS. This absolutely would not be the case were the procedure indeed "medically necessary".

Medically necessary treatments must be based on standards of practice, must be evidence-based, peer-reviewed and without bias or conflict of interest among the researchers or agency providing the recommendations, and there is almost always consensus among the medical community as to not only the necessity of the treatment/ procedure, but further, the preferred treatment. These factors establish standard of care, and physicians are derelict in their duties when they stray from these critical considerations. Unfortunately, in the case of GRS in the treatment of gender dysphoria, none of these factors are true. Most notably, the entity most often referred to for guidance regarding treatment of gender dysphoria, namely WPATH (World Professional Association for Transgender Health), simply does not meet these criteria.

WPATH remains under increasing scrutiny and continues to be mired in controversy for the very reasons cited above, calling into question its objectivity and the very real concern that it is not the typical professional organization that develops reliable clinical practice guidelines. WPATH is considered by many to instead be a hybrid professional and activist organization, where activists have become voting members, and even move on to lead the organization. In fact, it is argued by many that WPATH is "activist-led" rather than "evidence-led", and therefore are not a reliable agency in medical decision making for our patients.

Conflicts of interest among the organization are also of significant concern. The overwhelming majority of WPATH Committee members either receive income based on recommendations in the guidelines, work at clinics or universities who receive funds from advocacy groups, foundations, or pharmaceutical companies who heavily favor a certain treatment paradigm, or have received grants and published papers or research in transgender care.

The majority of the members of the WPATH Committee are from the U.S., and six of them have affiliations with the same university–the University of Minnesota Program in Sexuality, which is primarily funded by a transgender advocacy organization (Tawani Foundation).

As if the factors above were not concerning enough, the situation becomes more concerning when we consider another source we as practitioners use to develop treatment plans for our patients, namely specialty societies. In the case of WPATH, three of the same committee members for the WPATH Guidelines also served on the Endocrine Society guideline committee, which raises intellectual conflict of interest concerns, as recommendations based on faulty conclusions in the WPATH guidelines could potentially have been duplicated in the Endocrine Society guidelines.

When, as clinicians we encounter concerns related to objectivity or conflict of interest, for instance, a study recommending a particular pharmacologic treatment or prosthetic device wherein the study was funded by the pharmaceutical company or prosthetic manufacturer, we are then obligated to expand our research and consider other studies. To do otherwise as medical professionals would be negligent; we simply cannot rely solely on a single organization with these concerns at the forefront in making decisions for our patients. This is precisely the case here, where there is significant concern for objectivity and conflict of interest among WPATH, as well as the US Endocrine Society.

When further research is conducted, as we have done in this case, it becomes even more apparent why there is indeed not consensus among the medical community in the treatment of gender dysphoria, and particularly GCS.

Perhaps one of the most important considerations in developing treatment plans for our patients is the long term prognosis following the treatment. Most critically, the imperative "*Primum non nocere*", ("First do no harm") must be at the forefront of consideration. This imperative is the underpinning of the oath all physicians take. In order to ensure the most appropriate, effective, and safest care to patients, clinicians must exercise due diligence in evaluating all available information in formulating recommendations to patients. The evidence regarding GRS does not provide sufficient confidence that the procedures should be undertaken without concern for having violated that oath.

Case in point is the 2016 CMS (Centers for Medicaid and Medicare) Decision Memo which summarizes the following: "Based on a thorough review of the clinical evidence available at this time, there is not

enough evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria". Further in the report, "When considering even the 'best studies', the conclusion was that there is no evidence of 'clinically significant changes' after sex reassignment surgery." (NCA - Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N) - Proposed Decision Memo (cms.gov))

No studies conclusively demonstrate that GCS improves quality of life or sufficiently addresses gender dysphoria. In fact, in the largest and most thorough long term study looking at quality of life after GCS [Sweden; 324 individuals over a 30 year period (1973-2003)] (Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden (plos.org)), found evidence to the contrary. Specifically, 1-15 years after surgical reassignment, the suicide rate of those who had undergone sex reassignment surgery rose to 20 times that of comparable peers; there was notable increased mortality and psychiatric hospitalization (which was 2.8 times greater than in controls). As/ more interesting was the finding that death due to neoplasm and cardiovascular disease was increased 2-2.5 times in the surgical group, and this increased mortality was not realized for some 10 years after surgery.

There is a growing body of research into what seems to be an increasing number of transgender individuals who at some point "de-transition", or go back to living as their sex assigned at birth (or at least discontinue some or all aspects of gender affirmation).

The phenomenon of de-transition is critically important in considering treatment options for patients, particularly when treatment involves either irreversible or incredibly difficult/ poor outcomes, such as surgeries. This consideration is of even greater concern when the veracity of the patient is in question or there are other factors such as secondary gain to be considered.

A study recently (June 2021) published by the National Institutes for Health (National Center for Biotechnology Information-NCBI) found that among individuals who had undergone transition, more than 13% had undergone de-transition. Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis (nih.gov)

Further analysis of this data demonstrated that of those who de-transitioned, 38% did so because transitioning had failed to resolve their psychological issues, so they concluded that "gender dysphoria wasn't the cause"; another 23% did so because they came to understand that they had in fact been struggling with sexual orientation issues rather than gender dysphoria. Why Some Transpersons Decide to Detransition | Psychology Today

A large sample, peer-reviewed study conducted in 2021 found that 70% of those who detransitioned did so after they realized their gender dysphoria was "related to other issues" and 50% did so because transition had failed to alleviate their dysphoria. Interestingly, 43% endorsed a "change in political views" as a reason for detransition. Importantly, 43% of those who detransitioned had previously undergone GCS. Full article: Detransition-Related Needs and Support: A Cross-Sectional Online Survey (tandfonline.com)

Another more recent study (Oct 2021) found that 70% were dissatisfied with their decision to transition. 61% of those who detransitioned had returned to their identifying with their birth sex, 14% identified as nonbinary, and 8% identified as transgender. The study goes on to emphasize the need for "alternative,

non-invasive approaches for gender dysphoria management in young people".
Growing Focus on Detransition | SEGM

Having taken all these factors into consideration, it remains my medical determination that the surgical procedure requested by this offender is not medically necessary. Further, there is increasing evidence that GRS does not represent the definitive treatment for gender dysphoria, nor does the literature provide the confidence in long-term success required in order to undertake invasive procedures. There simply is not consensus among the medical community that GRS represents THE only acceptable nor THE most recommended treatment for gender dysphoria. In no other context would surgery be considered for a patient if at least one of these factors were not considered to be consensus among the medical community.

APPENDIX H

Division Transgender Accommodations Review Committee (DTARC) Position Statement

Gender Reassignment Surgery

NCDPS-Prisons

23 March 2022

Dr Arthur L Campbell, III, M.D.

Chief Medical Officer, NC Prisons

SUMMARY POSITION STATEMENT:

As with all treatments, including procedures and surgeries provided to offenders, the first consideration is whether the treatment is medically necessary. This consideration is precisely the same as that utilized by every managed care system and health insurance agency in the Country.

After extensive and objective review and analysis of hundreds of studies and other publications, it has been determined that gender reassignment surgery (GRS), as a treatment for gender dysphoria, is not medically necessary.

When GRS is considered with and compared to other procedures and surgeries which are broadly considered medically necessary, GRS procedures fail to satisfy the criteria and characteristics evidenced by those broadly accepted procedures. Specifically, there are concerns that the risk, as defined by failure of the procedure to correct the underlying problem or the need for subsequent reversal of the procedure outweigh any potential benefit of the procedure. GRS simply does not represent an objective "standard of care" and there are grave concerns with significant conflict of interest and the lack of evidence-based, peer-reviewed criteria utilized in developing criteria.

ANALYSIS/ DISCUSSION

There continue to be variable, and at times discrepant definitions of "medical necessity" between medical professionals, insurance providers, legislators, legal authorities, and activists. Across the country, the Courts continue to be somewhat inconsistent in their interpretations of what constitutes "medical necessity". These discrepancies become even more complex in the context of medical care for the prison population.

Broadly speaking, at the most basic level, a medically necessary procedure is one which is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. More specifically, there are fairly standard characteristics which most in the medical community would agree either constitute or are associated with a "medically necessary" treatment or procedure, and in the context of gender reassignment surgery (GRS), these characteristics can be applied to reach a determination.

Some prominent characteristics of "medically necessary" procedures include:

- The risk to the patient of not performing the surgery exceed the potential risks of the surgery itself (includes intraoperative, postoperative and long term risks).
- The procedure has been determined to constitute "standard of care", which leads to the following:
    - Overwhelming majority of individuals with the condition undergo the procedure
    - Majority of health insurance carriers provide coverage for the procedure, particularly when the procedure is not costlier than an alternative service or sequence of treatments that are at least as likely to produce equivalent therapeutic results.
- Treatment recommendations are developed through evidence-based medicine/ practice and are modified based on findings from continuous future studies.

When gender reassignment surgery is considered utilizing the general principles outlined above, it becomes apparent that the procedure(s) are indeed not "medically necessary". What follows is a summary analysis and explanation.

- **<u>For medically necessary procedures, the risk to the patient of not performing the surgery exceeds the potential risks of the surgery itself.</u>**

  From the definition above, it follows that for a "medically necessary" procedure, the consensus among the medical community would be that not undertaking the procedure (surgery) will of course fail to alleviate the symptoms associated with the condition, but most importantly, could also result in one/ more of the following: (1) Death, (2) Severe disability, or (3) Significant worsening of the condition. A procedure which is unlikely to improve symptoms, carries with it increased risk of worsening symptoms, or those that disproportionately jeopardize a patent's well-being would not be considered "medically necessary". In fact, they would instead likely not be recommended at all.

  In the case of GRS, it is far from consensus among the medical community that individuals with gender dysphoria who do not undergo the procedure(s) are at increased risk of any of the sequelae outlined above. In fact, there are studies which cause great concern that a not insignificant portion of individuals who undergo the procedure(s) not only fail to improve, but in many cases, experience worse symptoms with quite concerning consequences.

  One example: The largest and longest term study looking at quality of life after GCS, conducted in Sweden with 324 individuals over 30 years (1973-2003), actually demonstrated a 20-fold increase in suicides and 2.8 times greater rate of psychiatric hospitalization. individuals also had a 2-2.5 times greater rate of neoplasm and cardiovascular disease. Importantly, many of these quite concerning outcomes did not occur until 10 years or more after surgery. [1]

  Studies demonstrating findings such as those above are not isolated. Another study in 2017, incidentally sponsored by a group that was clearly pro-transition, found that "suicide attempts were lower before transition than over most other periods". For example, the study found that suicidal ideation was 50.6% after transition compared with a 36.1% rate before transition. [2]

  Another important consideration in any surgical treatment is outcomes, including analysis of the need for further surgeries, etc. There is a growing body of research into what seems to be an increasing number of transgender individuals who at some point "de-transition", the act of stopping or reversing gender transition, often going back to living as their sex assigned at birth.

  This phenomenon of de-transition is critically important in considering treatment options for patients, particularly when treatment involves either irreversible or incredibly difficult/ poor outcomes, such as surgeries.

  A study published in the Archives of Sexual behavior in October 2021 found a 24% rate of de-transition. This study uncovered some interesting, and frankly concerning statistics. For example, 60% of those who de-transitioned did so at least partly because they had become more comfortable with their natal(birth) sex. A quite significant mount (49%) did so as a result of concerns about the potential medical complications from transitioning. Perhaps most

significantly, 55% expressed concerns that they had "not received adequate evaluations from a doctor or mental health professional before starting transition". [3]

Further analysis of this data and other studies demonstrated that of those who de-transitioned, 38% did so because transitioning had failed to resolve their psychological issues, so they concluded that "gender dysphoria wasn't the cause"; another 23% did so because they came to understand that they had in fact been struggling with sexual orientation issues rather than gender dysphoria. [4]

A large sample, peer-reviewed study conducted in 2021 found that 70% of those who de-transitioned did so after they realized their gender dysphoria was "related to other issues" and 50% did so because transition had failed to alleviate their dysphoria. Interestingly, 43% endorsed a "change in political views" as a reason for de-transition. Importantly, 43% of those who de-transitioned had previously undergone GCS. [5]

Another more recent study (Oct 2021) found that among individuals who de-transitioned, 70% did so due to being dissatisfied with their decision to transition. 61% of those who de-transitioned had returned to their identifying with their birth sex, 14% identified as non-binary, and 8% identified as transgender. The study goes on to emphasize the need for "alternative, non-invasive approaches for gender dysphoria management in young people". [6]

Findings such as these raise serious concerns and tip the "risk-benefit" analysis away from the support for surgery among objective medical observers, thereby refuting its "medical necessity".

- **<u>"Medically necessary" procedures are by definition considered to constitute "standard of care".</u>**

  If a procedure (surgery in this case) were the "standard of care", there would be a single, or at most a discrete subset of procedures which have been determined by the medical community to be most appropriate to treat the condition.
  - ***There are specific criteria which indicate not only the "qualification" for surgery, but also the specific procedure or approach would be best***
  - ***There are specific criteria which determine relative or absolute contraindications to surgery***
  - ***Based on these standards, the overwhelming expectation would be that (excluding patients who decline surgery against medical advice), that virtually every patient with this condition (and without contraindications) would indeed be provided the procedure.***
  - ***Majority of health insurance carriers provide coverage for the procedure, particularly when the procedure is not costlier than an alternative service or sequence of treatments that are at least as likely to produce equivalent therapeutic results.***

When evaluating and researching these factors in the context of GRS, it becomes readily apparent that GRS indeed does not satisfy the requirements necessary for it to be considered "standard of care".

The justification used by those who advocate for surgeries is that they are "necessary" in order to alleviate the "dysphoria" associated with the condition. However, unlike other "medically necessary" surgeries, where there is single or at most a very discrete set of established procedures, in the case of GRS, there is a wide spectrum of continually expanding surgical options designed to treat gender dysphoria.
While not all inclusive, these potential surgical options include (not all inclusive) mastectomy, mammoplasty, orchiectomy, penectomy, metoidioplasty, scrotoplasty, vulvoplasty, vaginoplasty, phalloplasty, voice feminization surgery (anterior glottal web formation; cricothyroid approximation; laser reduction glottoplasty), chondrolaryngoplasty, facial feminization/ masculinization surgery, hip augmentation/ enhancement, gluteal augmentation/ reduction, body contouring and fat transfer, and others.

What this list makes very evident is that there is clearly no established specific (or even series of surgeries) which is the "standard" in the treatment of gender dysphoria. Instead, clinicians and advocates involved in the care of patients with gender dysphoria believe that the extent, type and number of surgeries an individual "needs" ("upper" and/ or "lower") are quite literally determined by what makes the patient feel "complete" (or what they "choose"). Unlike pre-operative evaluations for other surgeries (such as a CT scan, MRI, biopsy, etc), in the case of gender dysphoria, there are no objective studies of any kind that can be performed to either determine indications for surgery or to develop specific surgical recommendations; these

determinations are purely subjective on the part of the individual. These facts alone make it clear that none of these surgeries can in any way be considered "necessary".

Over time, for most every surgical procedure, criteria and pre-operative evaluations are continually refined in order to ensure the procedures are offered only to those patients who are most likely to benefit from the procedure. Data is collected continuously and that data helps to not only identify the best candidates for a particular surgery, but also to determine those who are not likely to benefit, and most importantly, those who have risk factors which would contraindicate the surgery.

In the case of GRS, the opposite is true. Treatment advocacy groups continue to significantly relax criteria to the point where it is simply a matter of the individual "asking" for the procedure(s). In fact, their approach to individuals with gender dysphoria has just recently been updated to an "informed consent model"/ "affirmation only" model, which "seeks to better acknowledge and support patient's right of, and their capability for, personal autonomy in choosing care options without the requirement of external evaluations or therapy by mental health professionals" [7]

Another important consideration is the fact that for traditional "medically necessary" surgeries, the overwhelming majority of patients with the condition (unless there are specific contraindications or the patient declines), will indeed end up undergoing the procedure. This too is not the case at all with GRS. In fact, only 25-35% of individuals with gender dysphoria ever undergo any GRS. [8]. This further substantiates the case that GRS for the treatment of gender dysphoria is indeed not "medically necessary", as the vast majority of individuals never undergo these procedures. That is not the case at any truly "medically necessary" surgeries.

Another factor with "medically necessary" procedures (again, which equates to being the "standard of care") is that due to these procedures being established as the "standard of care", the majority of health insurance carriers provide coverage for the procedure, particularly when the procedure is not costlier than an alternative service or sequence of treatments that are at least as likely to produce equivalent therapeutic results. This too is not true when evaluating the current state of health insurance coverage for GCS.

At the federal level, CMS (Centers for Medicare and Medicaid), after an exhaustive review of hundreds of studies in 2016, concluded that the procedures would not be mandated as part of Medicare plans due to the conclusion that there is a "lack of evidence that the procedures benefits patients". More specifically, the Decision Memo stated the following: "Based on a thorough review of the clinical evidence available at this time, there is not enough evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria", and went on to conclude that there is no evidence of "clinically significant changes" after GRS. [9]

Similarly, at the State level, while there are expected variations, 64% (32) of States' Medicaid Programs also do not provide GRS coverage. [10] Further, most State Employees' Health Plans (including North Carolina) do not provide coverage for GRS.

When specifically considering GRS in prisons, it is important to note that there have been no Federal inmates who have received GRS and only two states to date have provided for the procedure, both of which were very discrete circumstances in court settlements. Were GRS indeed "medically necessary", not providing the procedure would bolster court cases regarding the 8th Amendment to the US Constitution. However, this has not been the case. Recent court rulings on this have been inconsistent to say the least. In fact, cases in both the First and Fifth Circuit Courts of Appeal have concluded that the State prison systems did not violate inmate's rights (did not inflict "cruel and unusual punishment") by declining provision of GRS for inmates.

More specifically, in the Fifth Circuit Court of Appeals case (March 2019; Gibson v Collier), in its findings, the Court confirmed that *"it is indisputable that the necessity and efficacy of sex reassignment surgery is a matter of significant disagreement within the medical community. As the First Circuit has noted—and counsel here does not dispute—respected medical experts fiercely question whether sex reassignment surgery, rather than counseling and hormone therapy, is the best treatment for gender dysphoria."*
Further, the Court provided the following explanation:
"Under established precedent, it can be cruel and unusual punishment to deny essential medical care to an inmate. But that does not mean prisons must provide whatever care an inmate wants. Rather, the Eighth Amendment "proscribes only medical care so unconscionable as to fall below society's minimum standards of decency." Interestingly, the Court went on to point out that something (in this case, GRS) cannot be "unusual" if doing so is not the "usual" treatment, which is clearly the case in the context of GRS in either prisons or across the country as a whole. [11]

None of these would be the case were GRS indeed the "standard of care" and the procedures were "medically necessary", which further bolsters the case that these procedures are indeed not medically necessary.

- **Treatment recommendations are developed through evidence-based medicine/ practice and are modified based on findings from continuous future studies.**

  Surgical procedures are determined using evidence-based, peer-reviewed medical studies which are free of bias or conflict of interest, leading to near consensus among the medical community as to not only the necessity of the treatment/ procedure, but further, the preferred treatment.

  - ***Critically important is that these studies continually evaluate (and modify based on the data obtained) the pre-operative, intra-operative, post-operative, and long term approaches and prognosis associated with the procedure.***

  This factor associated with evaluating medical necessity for any procedure is critical in order to ensure the best care for our patients, and in the case of GRS, is perhaps one of the most concerning factors. Unfortunately, in the case of GRS in the treatment of gender dysphoria, this level of scrutiny is simply not present. Most notably, the entity most often referred to for guidance regarding treatment of gender dysphoria, namely WPATH (World Professional Association for Transgender Health), simply does not utilize these criteria in developing their "standards of care". This realization has led to individuals/groups, who are supportive of treatments for gender dysphoria but who lack confidence in WPATH, establishing other organizations in order to ensure the level of scrutiny needed in undertaking these procedures.

  For example, the Society for Evidence-Based Gender Medicine (SEGM) has recently been established by a physician in Oregon who has grown increasingly concerned with the lack of objectivity displayed by WPATH, stating that the organization "remains captured by activists". "We need a serious organization to take a sober look at the evidence and that is why we have established the Society for Evidence-Based Gender Medicine [SEGM]," she noted. "This is what we do — we are looking at all of the evidence. "She specifically recommends the WPATH SOC not be "the new gold standard going forward, primarily because it is not evidence-based". Instead, she points out that "WPATH utilizes the 'Delphi consensus process' to determine their recommendations, but this process is designed for use with a panel of experts when evidence is lacking". Instead of a panel of experts, she and an increasing number of other physicians across the country view WPATH as a "panel of activists" instead of a panel of experts. [12]

  Medically necessary treatments must be based on standards of practice, must be evidence-based, peer-reviewed and without bias or conflict of interest among the researchers or agency providing the recommendations, and there is almost always consensus among the medical community as to not only the necessity of the treatment/ procedure, but further, the preferred treatment. These factors establish standard of care, and physicians are derelict in their duties when they stray from these critical considerations.

  Unfortunately, the literature often relied upon is fraught with study design problems, including convenience sampling, lack of controls, cross-sectional design, small sample sizes, short study lengths, and enormously high drop-out rates among participants. Very few studies on transition escape these issues. For example, a 2018 systematic review of quality-of-life studies of transitioned adults rated only two out of twenty-nine studies as high-quality. [13]

WPATH remains under increasing scrutiny and continues to be mired in controversy for the very reasons cited above, calling into question its objectivity and the very real concern that it is not the typical professional organization that develops reliable clinical practice guidelines. WPATH is considered by many to instead be a hybrid professional and activist organization, where activists have become voting members, and even move on to lead the organization. In fact, it is argued by many that WPATH is "activist-led" rather than "evidence-led", and therefore are not a reliable agency in medical decision making for our patients.

Conflicts of interest among the organization are also of significant concern. The overwhelming majority of WPATH Committee members either receive income based on recommendations in the guidelines, work at clinics or universities who receive funds from advocacy groups, foundations, or pharmaceutical companies who heavily favor a certain treatment paradigm, or have received grants and published papers or research in transgender care. [14]

The majority of the members of the WPATH Committee are from the U.S., and six of them have affiliations with the same university–the University of Minnesota Program in Sexuality, which is primarily funded by a transgender advocacy organization (Tawani Foundation). In fact, the current chairman of WPATH has his very position at the University of Minnesota funded by Jennifer Pritzer, a trans person and head of Tawani. In fact, there are press releases of Eli Coleman in 2017 thanking Jennifer Pritzer profusely for a generous donation, which adds up to 6.5 million dollars that Tawani has given to the university. Tawani also funded WPATH SOC development. Another advocacy group, Gender Identity Research and Education Society (GIRES) funded the translation of the SOC into various languages. [14]

As if the factors above were not concerning enough, the situation becomes more concerning when we consider another source we as practitioners use to develop treatment plans for our patients, namely specialty societies. In the case of WPATH, three of the same committee members for the WPATH Guidelines also served on the Endocrine Society guideline committee, which raises intellectual conflict of interest concerns, as recommendations based on faulty conclusions in the WPATH guidelines could potentially have been duplicated in the Endocrine Society guidelines.

This concern is supported by the fact that ECRI (Emergency Care Research Institute), the DHHS-appointed Agency for Healthcare Research and Quality (AHRQ) for the National Guideline Clearinghouse (NGC), has failed to provide Trust Ratings for either WPATH or the Endocrine Society guidelines for the treatment of gender dysphoria. The reason for this lack of inclusion was because "only a few of the recommendations were supported by the systematic review; the majority were not", and that the agencies "did not use a systematic review process" in developing their guidelines. [14]

When, as clinicians we encounter concerns related to objectivity or conflict of interest, for instance, a study recommending a particular pharmacologic treatment or prosthetic device wherein the study was funded by the pharmaceutical company or prosthetic manufacturer, we are then obligated to expand our research and consider other studies. To do otherwise as medical professionals would be negligent; we simply cannot rely solely on a single organization with these concerns at the forefront in making decisions for our patients. This is precisely the

case here, where there is significant concern for objectivity and conflict of interest among WPATH, as well as the US Endocrine Society.

When further research is conducted, as we have done in this case, it becomes even more apparent why there is indeed not consensus among the medical community in the treatment of gender dysphoria, and particularly GCS.

In summary, based on the extensive and objective review of hundreds of studies and other publications, it is quite clear that gender reassignment surgery as a course of treatment for gender dysphoria is indeed not a medical necessity. When GRS is considered with and compared to other procedures and surgeries which are broadly considered medically necessary, the procedures fail to satisfy the criteria and characteristics evidenced by those procedures. Specifically, there are concerns that the risk, as defined by failure of the procedure to correct the underlying problem or the need for subsequent reversal of the procedure outweigh the potential benefit of the procedure. GRS simply does not represent an objective "standard of care" and there are grave concerns with significant conflict of interest and the lack of evidence-based, peer-reviewed criteria utilized in developing criteria.

Accordingly, to support these procedures given all these concerns would be in conflict with the most critical imperative in medicine, "*Primum non nocere*" (First, do no harm"). This imperative is the underpinning of the oath all physicians take. In order to ensure the most appropriate, effective, and safest care to patients, clinicians must exercise due diligence in evaluating all available information in formulating recommendations to patients. The evidence regarding GCS does not provide sufficient confidence that the procedures should be undertaken without concern for having violated that oath.

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[3] Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners | SpringerLink

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[5] Why Some Transpersons Decide to Detransition | Psychology Today

[6] Full article: Detransition-Related Needs and Support: A Cross-Sectional Online Survey (tandfonline.com)

[7] Demographic and temporal trends in transgender identities and gender confirming surgery (nih.gov)

[8] Growing Focus on Detransition | SEGM

[9] Informed Consent in the Medical Care of Transgender and Gender-Nonconforming Patients | Journal of Ethics | American Medical Association (ama-assn.org)

[10] NCA - Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N) - Proposed Decision Memo (cms.gov)

[11] Issue brief: Health insurance coverage for gender-affirming care of transgender patients (ama-assn.org)

[12] Gibson v. Collier, No. 16-51148 (5th Cir. 2019) :: Justia

[13] WPATH Draft on Gender Dysphoria 'Skewed and Misses Urgent Issues' (medscape.com)

[14] Quality of life of treatment-seeking transgender adults: A systematic review and meta-analysis | SpringerLink

[15] Bias, not evidence dominates WPATH transgender standard of care - CANADIAN GENDER REPORT

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION
NO. 3:22-cv-191

KANAUTICA ZAYRE-BROWN,

Plaintiff,

vs.

NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY, et al.,

Defendants.

VIDEOTAPED DEPOSITION OF

KANAUTICA ZAYRE-BROWN

(Taken on behalf of Defendants)

Polkton, North Carolina

January 18, 2023

REPORTED BY: Kristy L. Clark, RPR, NV CCR #708,
CA CSR #13529, NC Notary #201807900150

Huseby Global Solutions Job. No. 433362

CONTAINS GENERAL CONFIDENTIAL INFORMATION

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I N D E X

INDEX TO EXHIBITS

(None marked.)

Videotaped Deposition of KANAUTICA ZAYRE-BROWN, taken on behalf of the DEFENDANTS, at 552 Prison Camp Road, POLKTON, North Carolina, on Wednesday, January 18, 2023, at 10:04 a.m., before Kristy L. Clark, Registered Professional Reporter and Notary Public.

P R O C E E D I N G S

-oOo-

THE VIDEOGRAPHER: Good morning. We are now going on the record. This is the beginning of Media Number 1 in the videotaped deposition of Kanautica Zayre-Brown in the matter of Kanautica Zayre-Brown, v. North Carolina Department of Public Safety, et al., Case No. 3:22 --

(Interruption in proceedings.)

THE VIDEOGRAPHER: -- Case No. 3:22-cv-191. Today's date is January 18th, 2023, and the time on the monitor is 10:04 a.m.

My name is Andrew Smith, and -- and I am the videographer. And our court reporter is Kristy Clark. We are here with Huseby Global Litigation.

Counsel, please identify yourselves after which our court reporter will swear in the witness.

MS. MAFFETORE: Jaclyn Maffetore with the ACLU of North Carolina for Ms. Zayre-Brown.

MR. SIEGEL: Daniel Siegel with the ACLU of North Carolina for the plaintiff.

MS. DELGADO: Good morning. Michelle Delgado with ACLU of North Carolina for the plaintiff.

MS. ROBBINS: And I am Lauren Robbins with

the ACLU of North Carolina for the plaintiff.

MS. BRENNAN: Stephanie Brennan for the defendants. And I am from the attorney general's office.

MR. RODRIGUEZ: Orlando Rodriguez, also from the attorney general's office, representing the defendants.

Thereupon--

KANAUTICA ZAYRE-BROWN,

was called as a witness, and having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. RODRIGUEZ:

Q. Good morning, Kanautica.

A. Good morning.

Q. My name is Orlando Rodriguez. I represent the defendants in this case, and I'm going to take your deposition today. Before I do that, I'm going to ask you a few sort of background-ish questions, more mechanical questions.

Have you ever been deposed before?

A. No.

Q. What was that?

A. No.

Q. Okay. So one of the things I want to sort of touch on is related to -- to that. So you're being videotaped, and the court reporter is taking down basically verbatim notes of what we're saying, and it's being recorded.

But when -- and I'm looking at you, so I can see when you nod or when you shake your head, just like you did, but if I ask you a question for which an answer is either "yes" or "no," naturally, we want to shake our head or nod, and you can do that, but you also need to follow up with a verbal "yes" or a "no," and try to avoid the "uh-huhs" or "huh-uhs."

And I'll try to catch it, if I notice it, but sometimes I don't. The court reporter may catch it. But if you can do me a favor and try to -- try to verbalize your answers rather than visually moving your body, that will help us keep a cleaner record, so later when we go to review the transcript and whatnot, we know exactly what your answer was to -- to my question.

And along those same lines, if I ask you a question and you don't understand the question, it's probably my fault. It's likely that I asked a -- probably a really wordy question that didn't make much sense, and so you need to tell me, "I don't understand; can you rephrase it?"

I will not take offense. I will do my best to -- to rephrase the question. Because I want you to answer the questions as you understand them, and not as you, you know, think that I'm asking. I want you to answer questions that you understand me to be asking and not, you know, giving me an answer something that you, like, I guess that's what he meant. Because we want to know -- have a record of what you said in response to specific questions.

Similarly, I can be a fast talker, but I try, and I've been practicing to try to slow down. It's really hard for me do that in a deposition, easier in court. But I don't know your cadence of speech, but if you also are a fast talker, for the benefit of the court reporter, primarily, if we can try to -- try to slow our pace down so that we're answering the -- or talking in a way that the court reporter can easily capture that.

And along those same lines, I will do my very best to let you complete your answer to a question before I ask a follow-up question. And if you could do me the same courtesy and let me finish my question before you start to answer, that does a couple of things.

One, it keeps the -- the flow of conversation

easy, but two, it prevents us from talking over one another so that the record, again, is -- is clear, so there's a very easy to follow question, answer, question, answer, rather than talking over one another.

Let me see here. Make sure I got everything.

During the course of the deposition, your -- your attorney -- you have three of them here, but I presume only Jaclyn is going to be making objections, if necessary, on the record. So Jackie --

MR. RODRIGUEZ: Jackie, can I call you Jackie? Jaclyn?

MS. MAFFETORE: That's fine.

BY MR. RODRIGUEZ:

Q. -- may -- may object. If she does object, if she says "objection," if you're in the process of answering, you can stop your answer, let her lodge her objection for the record. And unless she instructs you otherwise; however, we'd like for you -- you're going to need to answer the question even though she objects. Unless, of course, there's a specific instruction from your lawyer to not answer a particular question.

We're going to take a break. We're not going to go marathon style. That's not -- you know, I've got a water here, so I'm going to need to take a break at some point. So -- but that being said, if you need a

break at some point in the deposition, that's fine. You can ask to stop. The only thing I would ask is that if you do request a break, that if there's any question pending, that you answer the question before we take a break.

Does that make sense?

A. Yes, sir.

Q. Okay. Are you taking any medications or any other substances today that could affect your ability to testify truthfully?

A. No, sir.

Q. Are you taking any substances or medications today that would affect your -- your memory?

A. No, sir.

Q. Is there any other reason that you can think of that would prevent you from answering questions truthfully today?

A. No, sir.

Q. Okay. Before this deposition today, in preparation of this deposition, have you reviewed any documents?

A. Yes, sir.

Q. Which ones were those?

MS. MAFFETORE: Objection to work product.

MR. RODRIGUEZ: Okay.

BY MR. RODRIGUEZ:

Q. So did you review any documents that were not prepared by your attorneys?

A. No, sir.

Q. Okay. So you didn't review any of your grievances, any of your requests for informations, any of your ADA requests or anything like that?

A. No, sir.

Q. And aside from your attorneys, have you spoken with anyone in preparation for this deposition?

A. No, sir.

Q. All right. So that's all the mechanical stuff out of the way. We have to do that kind of stuff with everybody before we start asking the real questions.

Can you state for the record your full name and date of birth?

A. Kanautica Promises Zayre-Brown, 9/23/1981.

Q. And where were you born?

A. Wilson, North Carolina.

Q. And were you born in Wilson city limits?

A. Yes.

Q. And did you live in Wilson after you were born?

A. Yes.

Q. Any -- anyone in particular?

A. Yes, the Southern Justice -- Southern Coalition for Social Justice in Durham.

(Clarification by the reporter.)

BY MR. RODRIGUEZ:

Q. Is that the only one?

A. That's the only one.

Q. Now, you mentioned the -- the law school. What -- describe your highest level of education.

A. Master's.

Q. You have a master's degree?

A. Yes.

Q. And what did you -- what did you study?

A. Social work.

Q. And when did you receive that degree?

A. 2008.

Q. And what institution did you graduate?

A. Liberty University.

Q. Liberty University?

A. (Witness nods head.)

Q. Okay. So then I assume -- do you have a high school diploma?

A. No, I got a GED.

Q. GED. When did you get your GED?

A. In 2000.

Q. And what about college or post-secondary courses after your GED?

A. GED was at Mayland Community College. My undergrad was at Louisiana Baptist University.

Q. And when did you -- did you receive an undergraduate degree?

A. Yes.

Q. When did you receive that?

A. 2004.

Q. And what was your undergraduate degree in?

A. Psychology.

Q. All right. So we've got a GED through Mayland Community College. We've got a -- was it a bachelor of arts or a bachelor's of science?

A. A bachelor of arts.

Q. You got a BA from Louisiana Baptist in 2004. And then we have a master's of social work from Liberty University in 2008. Do you have any other degrees from other higher educational institutions?

A. I have diplomas for paralegal studies through Blackstone Career Institute. I got a specialized certificate for civil litigation and business and corporate law through Blackstone Career Institute.

Q. And when did you receive those certificates and diplomas?

A. 2020, 2021, and 2022.

Q. So aside from Liberty University, Mayland Community College, Louisiana Baptist, and -- and Blackstone, have you taken any other courses from any other institutions?

A. The rest are just self-enrichment vocational classes.

Q. And what about online or correspondence courses?

A. Those were my grad -- my undergrad and my graduate degree come from.

Q. Okay. So your 2004 from the Louisiana Baptist and your '08 from Liberty were online?

A. Yes. And the corr- -- and Blackstone was correspondence as well.

Q. Okay. So no other educational history to report?

A. No.

Q. All right. Now, before you entered DPS custody in October of 2017, were you under the care of any -- any healthcare providers?

A. Yes.

Q. Can you tell me which ones?

A. UNC psychiatry and UNC endocrinologist, Dr. Hope Sherie at Concierge Cosmetics in Charlotte,

North Carolina.

Q. Okay. Did you have a primary care provider before you entered in October of 2017?

A. Not primary care.

Q. No. So you didn't have a regular doctor, physicals and stuff?

A. I did all that through endocrinology.

Q. Okay. And how long were you going to UNC endocrinology?

A. Since 2010.

Q. Okay.

A. No, 2012 with endocrinology. Psych from 2012.

Q. So 2012 up until your incarceration in 2017 --

A. Right.

Q. -- you were treated through UNC endocrinology?

A. Right.

Q. And then 2010 to 2017, UNC psychiatry you said?

A. UNC psychiatry after 20 -- I don't remember when it ended, but it was in 2017.

Q. Okay. It was before?

A. Yeah.

Q. Before then? Okay. And then you mentioned the Dr. Hope Sherie out of Charlotte. What kind of physician is she?

A. She's a cosmetic surgeon for gender-affirming care.

Q. Did you have any other mental -- did you have mental health providers beyond any care you received from UNC psychiatry prior to entering custody?

A. No.

Q. So you weren't seeing a therapist?

A. That's what was going -- that was through the psychiatry services. They did -- the psychologist was through them.

Q. Okay. And so outside of UNC psychiatry, were you seeing any -- any therapists?

A. No.

Q. And what locations would you receive treatment from UNC endocrinology?

A. High Tower -- UNC High Tower. It was between Durham and Chapel Hill.

Q. And was both the endocrinology and psychiatry at the same location?

A. They was not far apart.

Q. Okay. But both at the High Tower?

A. No. UNC was at High Tower. UNC psychiatry

was at a different location, but it was close to High Tower. I don't remember the actual name of it, like the location.

Q. And for both of these specialty care, the endocrinology and the psychiatry, did you go to one location consistently?

A. (Witness nods head.)

Q. So the endocrinology, was it only at High Tower?

A. Yeah, that's the only -- endocrinology I went to, and it changed once I came to prison and got switched over to Meadow Lark or something like that.

Q. And how did you end up seeing -- being -- being under the care of the UNC endocrinology program?

A. Through UNC psychiatry program.

Q. Okay. And how did you end up under the care of UNC psychiatry program?

A. Through my insurance.

Q. Through your health insurance?

A. Yes.

Q. And what health insurance did you have at that time?

A. I want to say it was Blue Cross Blue Shield.

Q. Was that an employer-provided plan?

A. Yes.

Q. And who was your employer at the time?
A. Holly Hill.
Q. And do you know how it was that you came to be referred to UNC psychiatry?
A. I looked in my in-network referrals.
Q. So you sought out the care; you weren't referred the care?
A. Like for psychiatry?
Q. Uh-huh.
A. No, I looked at it to see what services was available in my network, and I called and scheduled an appointment.
Q. With the UNC psychiatry?
A. Yes.
Q. And why did you do that?
A. Because I felt like I was suffering from -- at the moment, I didn't understand what it was called, gender dysphoria, but I felt like that it was something going on that I needed some clarification on.
Q. And this was 2010?
A. Yes.
Q. And so at that time, were you already under the care of -- or had you already received any surgical services from Hope Sherie?
A. No.

Q. And so UNC psychiatry then led you to UNC endocrinology?

A. Yes.

Q. What kind of services did you receive from UNC psychiatry?

A. Just psychotherapy. And -- and after psychotherapy, she offered a community support letter to start hormones.

Q. And who is "she"?

A. Dr. Jones.

Q. Dr. Jones?

A. Yes.

Q. And is this a medical doctor or physician or is this --

A. Psychologist.

Q. Psychologist? So it's a PhD doctor?

A. Yes.

Q. And do you recall Dr. Jones' first name?

A. Katrina I want to say.

Q. Did you ever -- Katrina Jones or we'll just say Dr. Jones. Any other mental health providers at UNC psychiatry?

A. No, sir.

Q. So what about a provider by the name -- last name Hans?

A. Dr. Hahn.
Q. Hans?
A. That was in prison.
Q. Hans was in prison?
A. H-a-h-n-s, Dr. Patricia Hahns?
Q. No, that's Patricia -- Dr. Hahn, H-a -- H-a-h-n. This is at UNC psychiatry. Do you recall any other providers at UNC psychiatry?
A. Not that I can remember.
Q. So you had some -- you had some talk therapy sessions. How regularly did you attend those sessions?
A. If I recall, at first, it was often. And then after that, it was like monthly until when I felt that I was -- needed some talking. I needed to talk to someone.
Q. And so first often, maybe weekly or more often than that?
A. I don't remember.
Q. Okay. And so then you said that UNC psychiatry referred you to UNC endocrinology. Was that to begin hormone treatment you mentioned?
A. Yes.
Q. And so when -- when did you start hormone therapy?
A. 2012.

Q. And who prescribed this treatment to you? What is the physician's name?

A. The first one, if I remember, was Sherman Yin was my first endocrinologist.

Q. Yean?

A. Yin.

Q. Yin?

A. Yeah, yeah.

Q. And do you recall any others?

A. There was a second one, but I don't remember her name.

Q. Now, before you started the endocrinology treatment or the hormone replacement therapy, who did you talk with -- outside of your medical care providers, who did you talk with about your interest in that?

A. My husband was my only person that I talked to about it.

Q. Did you speak about this with any of your family members?

A. I don't remember.

Q. And why did you seek out this -- this treatment?

A. I sought out hormone therapy to decrease my testosterone in my body and to get a more female look.

Q. So would you say that you had -- those were two of your objectives in seeking out that treatment?

A. It was the beginning.

Q. What was that?

A. It was the beginning, the start of my objectives.

Q. Okay. Well, what other objectives did you have in undergoing hormone therapy?

A. I wanted to have breast augmentation, and I wanted to create breast tissue so I wouldn't have to go through chest -- I mean chest expanders to expand my chest to wear them.

Q. And did you discuss these objectives with anybody?

A. Yes. My physician.

Q. And what -- what -- excuse me. What was the nature of your discussions with your physicians about your objectives?

A. My discussion was that I wanted to match the gender for which I knew I was and my body wasn't.

Q. What were you told about the prospects of the hormone replacement therapy actually achieving those objectives?

A. They let me know that it was stages and steps, but it would ultimately get me where I needed to

be.

(Interruption in proceedings.)

BY MR. RODRIGUEZ:

Q. What sort of -- what sort of relief were you hoping to gain from beginning the hormone therapy?

A. The beginning relief was to have a decrease in an arousal, morning arousals, afternoon arousals, to create breast tissue, to slow my hair growth, softening of the skin, and ultimately, to decrease my testosterone levels.

Q. And did you discuss these hopes with your -- with anybody?

A. My physician and my psychiatrist.

Q. Beyond the physician and the psychiatrist, have you -- did you discuss this with anybody else?

A. I had a few conversations about my augmentation hopes and how my hormones and stuff was going with my aunts and my husband.

Q. Okay. So you -- you did talk about the hormone treatment and your objectives with your family members?

A. Once I started taking them.

Q. And what were you told about the prospects of attaining the relief that you just described through taking hormones?

A. Can you rephrase it?

Q. Sure. Were you given any information about how likely it would be that the relief that you discussed, the decrease in arousals, creating breast tissue, decreasing hair growth, lowering testosterone, were you given any information about how likely it was that the hormone therapy would achieve those or provide that relief to you?

A. Yes. I was told that it will get me there, but it was -- it would ultimately decrease -- sorry. It would decrease it. It would decrease the testosterone by taking the hormones. They did tell me that I would have to get laser because the hair wouldn't stop growing; so I have to get laser.

They told me that my -- it would create breast tissue, but it would be a very long process to get -- to achieve the look that I was looking for. And the softening of the skin will happen over time. And then I remember them giving me like a flow sheet of showing me like the periods, how long that the periods would actually take.

Q. And what was the look that you were looking for?

A. A very feminine look.

Q. Now, before you began your hormone

replacement therapy, what kind of limitations did you feel you had that you were hoping the therapy could address?

A. Therapy help me address me understanding gender dysphoria and help me understand that I was trans.

Q. The hormone replacement therapy?

A. The hormone replacement therapy assisted me to begin my transition.

Q. So were there any limitations that you felt that you had, things that you either couldn't do or didn't like to do that you were hoping would be addressed by the hormone therapy?

A. Definitely. Outings, hobbies, family functions, being around other people with my spouse. Definitely socially, a lot of sociable issues.

Q. And did you discuss these limitations and your hopes that the hormone replacement therapy would address these limitations with anybody?

A. I addressed them, but I also let them know that I probably won't get the desire that I'm looking for.

Q. Who -- who is -- who's this that you let know?

A. I talked to my husband about it. I remember

talking to my Aunt Betty about it. We had a very emotional setting with her about it one day. And then I talked to the psychiatrist and the endocrinologist about it.

Q. And what did they tell you about the prospects of the hormone therapy helping you achieve these easing of the limitations?

A. That I would need to seek a cosmetic surgeon to have a breast augmentation. I need to see a nurse practitioner at a laser center to get lasered to address the beginning of my issues.

Q. So tell me a little bit about how the hormone replacement therapy, how that treatment, how it either achieved or didn't achieve the objectives and the relief that you had sought.

A. Hormone therapy did not achieve the objectives.

Q. Why not?

A. Hormone therapy is only designed to get you but so far. And my transition wasn't solely based off of just receiving hormone therapy.

Q. When you first started the hormones, were you -- do you feel you were reasonably informed of the -- the prospects of the relief that you would get from the hormones?

A. I think when I was informed about hormones, I was informed that taking hormones long-term can be more of a health issue to me than it would be for me to obtain the desires that I was looking for.

Q. And what were those desires?

A. To have breasts, to have a feminine appearance to be so I can socially transition to get me the fat that I needed in the feminine areas.

Q. So you mentioned earlier when I asked about limitations, you mentioned social out -- social outings, hobbies, family get-togethers perhaps. Were you unable to do those things before you began hormone therapy?

A. I was very shy. I was very not-so-out-in-the-open with them about it.

Q. And how did that change, if at all, after you started hormone therapy?

A. Mentally, hormone therapy helped me feel I was beginning my transitioning and helped me feel like I was becoming the woman that I wanted to be.

Q. Okay. What surgeries have you had?

A. I had breast augmentation. I have had facial feminization surgery. I had had a Brazilian butt lift. I had a bilateral orchiectomy. I had earlobe replacement surgery. I had double bunionectomy. I

think -- that's it.

Q. When -- which one of those surgeries, aside from the bunions, was the first surgery you had?

A. My first surgery was my breast augmentation.

Q. And when was that?

A. 2012.

Q. 2012?

A. Yes.

Q. And who performed that surgery?

A. Dr. Jacob Freiman at Coral Gable Cosmetics in Coral Gables, Florida.

Q. Okay. So at this time, were you under the care of UNC endocrinology?

A. Yes.

Q. And UNC psychiatry?

A. Yes.

Q. But you were residing in Florida?

A. No, I stayed in Raleigh.

Q. Okay. How did you come to find Dr. Freiman?

A. Looking up that there's a transgender-affirming surgery network that you can look in to get all your providers.

Q. Were there any providers in North Carolina that provided that care -- that surgery?

A. I don't recall.

Q. And did you pay for this surgery out of pocket?

A. Yes, I did.

Q. Now, this -- this breast augmentation, who did you talk about your interest in pursuing the surgery with?

A. Dr. Sherman Yin. I talked with -- and I talked with the psychologist at UNC.

Q. And what was your -- what was your hope in seeking out this procedure?

A. To have the feminine look that I needed.

Q. Would you -- are there any other objectives that you had in seeking out this procedure?

A. No, I didn't have no other objectives.

Q. And what about the feminine appearance that you were seeking, why was that something that you sought?

A. Because a woman is feminine.

Q. Was there any -- were there any issues in how you felt others perceived you?

A. Very much so.

Q. Can you tell me a little bit about that?

A. I felt that people looked at me as being a faggot, a punk, a sissy, queer, I -- instead of being a woman. I felt that people looked at me to say you

don't have the boobs that you -- women supposed to have. You don't have the bottom that a woman have. Socially, I just was not accepted.

Q. At this time, you were married; right?

A. No.

Q. You weren't married yet?

A. No.

Q. Had you met Mr. Brown?

A. Yes.

Q. Okay. Were you -- were you dating him at the time?

A. Yes.

Q. Okay. Were there aspects of your relationship with Mr. Brown that you were hoping would improve?

A. No. Dionne accepts me for me regardless.

Q. What about with your family?

A. They accept me regardless.

Q. Okay. What kind of relief were you seeking by pursuing the breast augmentation? And this I mean more along the lines of emotionally. Were you -- what were you hoping would -- would happen to you after the breast augmentation?

A. It validated me becoming the woman that I desired.

Q. And -- and why was this important? Why was this validation important to you moving throughout the world? I understand your relationship with your -- with your then boyfriend or fiance and family were unaffected by that, but what about your -- your life were you hoping would improve by having the breast augmentation from an interpersonal standpoint?

A. Yeah. I would say because my -- all of my surgeries is done based because it makes me happy, not appeasing my family or my spouse. It's done to address my dysphoria. It's done to address me not having to live in the body for which I was assigned, but having the opportunity to transition to the female that I know I am. That's why breast augmentation was the first but not last of all the surgeries that I did.

Q. Were there any -- are there any things that you -- activities or events in particular that you either refrained from engaging in or simply could not engage in prior to your breast augmentation that you were hoping you could engage in after the breast augmentation?

A. Yes. Dancing, swimming, wearing tight or short clothing. And even after my breast augmentation, I was still limited to just top appearance, not bottom appearance. So I was just more -- I had more focus on

my top to make me feel connected to myself and make me feel better. It kind of boosted my self-esteem, kind of made me feel better.

Q. What was the recovery like for the breast augmentation?

A. It took a little minute for it to recover being that I didn't have the skin. But I made it through, and I went back to work.

Q. Now, before you -- I should have asked this earlier, but before you started your -- your hormone therapy, how would you say your level of contentment was?

A. Zero.

Q. Zero? On a scale of 1 to 10 or 1 to 100? You pick.

A. Zero to infinity. I didn't have any kind of confidence. I didn't have any -- it was 0. It was flat line.

Q. Okay. And after you had -- after the -- you started the hormone therapy but before you had the breast augmentation, where would you put your level of contentment on that same scale?

A. I was slowly increasing. So I would say hormone therapy would probably put me about a 1 or a 2, and my breast augmentation probably boost me up maybe 5

or 6 points. I was slowly getting myself there.

Q. Okay. And so, for my purposes, what -- what would the top end? Are we talking about a 10- or 100-point scale?

A. If I was on a 100-point scale.

Q. A 100-point scale. So hormones give you 2 or 3 you said?

A. Yeah.

Q. And then another 5 or 6 from the breast augmentation?

A. Yes.

Q. After you had fully recovered from the breast augmentation, did you have any residual pain or scarring or limitations?

A. The scarring minimized to almost like no scarring -- no scarring. And pain was definitely there because, I went from nothing to a D cup, so it definitely was painful.

Q. And how did the recovery process compare to what you were told about the recovery process?

A. Identical.

Q. Identical?

A. (Witness nods head.)

Q. And what about the prospects of achieving the outcomes, the objectives, attaining the relief, how

would you sort of rank your -- the breast augmentation in service of those objectives?

MS. MAFFETORE: Object to the form. It's confusing.

MR. RODRIGUEZ: That was a bad question.

BY MR. RODRIGUEZ:

Q. That was one of those examples of a bad question.

A. Yeah, I was ...

Q. You mentioned some objectives that you had in seeking out the breast augmentation. How did the breast augmentation stack up to those objectives? Did they meet the objectives?

A. It met the topical -- the top surgery, top part of my body alignment of that objective.

Q. Did it improve your level of contentment, your self-esteem?

A. Uh-huh. It improved.

Q. How much would you say it improved your self-esteem?

A. If we off the point scale again, just a few points.

Q. And was that less or more than you had anticipated it would improve your self-esteem?

A. I think it achieved what my doctors told me

it was going to achieve, which would be you would go from having nothing to something, and it's going to make you feel that you are transitioning.

Q. Okay. At this time, were you still attending regular therapy sessions?

A. I'm not going to say they was regular then. I think they was become more as needed.

Q. At that time, however, when you were undergoing the breast augmentation surgery, were you still feeling self-conscious, still feeling out of place?

A. I was feeling somewhat out of place to a certain degree. I would feel out of place if I had to present myself somewhere where I had to be seen from past my augmentation down.

Q. In what context?

A. Sex, doing things again like my hobbies in sports, entertaining, stuff like that. Work.

Q. So in what context -- when you say see yourself from the top down, are you -- you mean clothed or unclothed?

A. Both.

Q. Okay. So obviously with sex there would be less clothing involved.

A. Yes.

Q. Beyond sex, what kind of activities would you engage in where you would be seen from the bottom down with no clothes?

A. Not with no clothes, like with clothes on, but I couldn't wear the things I really wanted to wear to match the top alignment of my body. Where I basically could wear, say, a low-cut blouse to show I had top surgery to give the illusion that as a female compared to I couldn't wear like, say, a shorter skirt or tighter clothing because I feel like it would reveal tucking.

I would feel like it would reveal not the look of the vagina. So I had to wear bigger clothes. I had to wear clothes that covered that area. I couldn't participate in sports or dancing and stuff with the fear of being seen coming untucked, things like that.

Q. What kind of sports did you like to engage in?

A. I love baseball, I love volleyball, and I love to swim.

Q. And having to -- to wear bigger clothes, that upset you?

A. Very much so.

Q. All right. So then, what was the next

surgery that you had after the breast augmentation?

A. I had body contouring.

Q. Body contouring?

A. Uh-huh.

Q. When did you have that?

A. I had that in 2014.

Q. And what is body contouring?

A. Where they actually -- where you put a biogel, which is a artificial fat, into the buttocks and the thigh area to give you more of like a voluptuous, more contoured body.

Q. Is that referred to perhaps as a Brazilian butt lift?

A. Yes. The only thing is with the Brazilian butt lift, I didn't have the lipo part of the stomach.

Q. So have you never had lipo of your stomach?

A. I didn't get the lipo of the stomach.

Q. Okay. Have you ever had lipo at all?

A. No, huh-uh.

Q. So you had -- in 2014, you said?

A. Uh-huh.

Q. You had body contouring, and it was artificial fat that was injected into your butt and upper thigh?

A. Yes.

Q. Okay. Where was -- who -- who performed that surgery or that procedure?

A. I don't remember the individual's name, but it was done in San Antonio, Texas. And I don't remember the name. I don't remember the name of the person or the center. It was in San Antonio.

Q. Was it like a freestanding clinic or was it associated with a hospital system?

A. Oh, yeah, it was free standing.

Q. Freestanding?

A. Yeah.

Q. Were you living in Texas at that time?

A. Yes.

Q. Now, who did you speak with about your interest in pursuing the body contouring?

A. I went through that same network, the transgender community network.

Q. But this time you didn't have to travel out of state?

A. No.

Q. Now, what was your aim in -- in having this procedure done? What were you -- why did you seek it out?

A. To align my body to be as feminine as possible.

Q. And did the desired femininity that you were seeking out include, what, a rounder butt? Is that what you were --

A. Yes, I wanted a big butt. I wanted wide thighs.

Q. Okay. So wider thighs, a bigger butt, were those your objectives --

A. Uh-huh.

Q. -- in seeking out the procedure? What was it about not having those things that you were hoping to change?

A. I felt boyish.

Q. What is that?

A. I felt very boyish.

Q. And so what was the relief that you were looking for in seeking out the body contouring procedure? To alleviate the feeling of feeling like a boy?

A. Yeah, to try to alleviate the dysphoria.

Q. Alleviate the dysphoria?

A. Uh-huh.

Q. What -- what was -- what would you say was causing your dysphoria at that time?

A. Me -- my body not aligning with my -- with me being a female, my body wasn't aligning to it.

Q. Specifically with regard to the size of your --

A. Yeah.

Q. -- waist and your --

A. Yes.

Q. -- and your butt?

A. Right.

Q. Or hips, I guess?

A. Yes.

Q. Now, before -- before the body contouring surgery -- I don't know if it's a surgery or procedure -- but before the body contouring procedure, were there -- were there physical limitations that you were hoping to ease or address? You mentioned the playing sports and swimming and dancing.

Can you describe some of the things that you were hoping you could do after body contouring that you were refraining from before body contouring?

A. I will -- to be, like, very honest, if I could have had afford to do everything at one time, I would had completed my whole alignment of my body at one time to alleviate anything that I was feeling. But being that I was not financially able to, I had to do everything in steps to align my body with -- to -- to transition to the female that I wanted to.

So the same objectives that I had when I was getting my breast augmentation were kind of the same objectives that I had when I got body contouring and other surgeries. And the same restrictions that I had were the same restrictions when I got one surgery compared to the next surgery.

Q. So there was nothing specific about the body contouring -- that you were hoping the body contouring would address by way of like a limitation?

A. It would help address my dysphoria.

Q. Aside from -- aside from addressing your dysphoria, were there any physical limitations that you were hoping would be eased by the body contouring?

A. Yes. The -- the appearance of being feminine. The feminine out to be more feminized, and that's why I did the body contouring.

Q. And did you discuss the -- the prospects of the body contouring making you feel more feminine with anybody?

A. Uh-huh.

Q. Who did you talk about that with?

A. The one who did my procedure, my husband, family. And at that time, I was a member of a church in Corpus Christi, and I went over it with the people there; so, yeah.

Q. And what were you told about the prospects that the body contouring would help your -- help you feel more feminine?

A. I was told it would give me the look -- when I put clothes on, it would give me more of a feminine look. It will make me feel more self-confident.

Q. What was the recovery like for this procedure?

A. I had to lay on my stomach for two days, or if I got up -- I just could not sit on my butt area or thigh area for two days.

Q. And did the body contouring, did it achieve the objectives of helping you feel more feminine?

A. It was a start.

Q. Did it improve your -- your contentment?

A. It helped.

Q. How much?

A. Just a little.

Q. Were you disappointed by the amount or was that expected?

A. I think I got what I expected.

Q. So now, on a 100-point scale, we were, like, at a 7 or 8 before body contouring, where would you say we are now after body contouring?

A. Maybe a 8 if we were at a 7.

Q. Did it satisfy the objective of relieving your dysphoria?

A. No.

Q. So on that 100-point scale, we're still 8 1/2 maybe?

A. No. Yeah, about 8 1/2.

Q. After the earlobe surgery?

A. Yeah.

Q. And this was in Clay County, Florida. Where were you living at the time?

A. Orange Park, which is in Clay County, Florida.

Q. Okay. Did you -- I'm assuming -- did you seek -- how did you find this particular --

A. Same network.

Q. Same network?

A. Uh-huh.

Q. All right. Now, the next surgery looks like it was two surgeries?

A. Yeah.

Q. The facial feminization surgery and the orchiectomy?

A. Yes.

Q. And when was that?

A. October -- I mean, July of 2017.

Q. So July 2017. So a few months before you enter custody -- DPS custody?

A. Uh-huh.

Q. And you had both surgeries at the same time?

A. Yes.

Q. And tell me first about the facial feminization surgery. What did they do?

A. So she put in permanent fillers into my chin area, my cheek area, and my forehead area to decrease the structure -- the square structure of the face to have more of a feminine look.

Q. And "she," was this Dr. Sherie?

A. Yes.

Q. Okay. And did you talk with anybody aside from Dr. Sherie about your interest in pursuing the facial feminization surgery?

A. No.

Q. No? What about with your husband or your family members?

A. Not at that time, no.

Q. Okay. So they didn't know that you were going to have --

A. No.

Q. -- facial feminization surgery?

A. Huh-uh.

Q. Okay. And what was the objective of having the facial feminization surgery?

A. To have a more of a feminine look.

Q. And the purpose for that was?

A. To help allieve [sic] my dysphoria.

Q. And did you discuss the prospects of the facial feminization surgery improving your dysphoria with anybody?

A. With the doctor.

Q. With Dr. Sherie?

A. Uh-huh.

Q. Did you discuss this with any mental health care providers?

A. No.

Q. Were there any physical limitations that you were hoping, activities that you were hoping to engage in before the surgery -- after the surgery that you couldn't before the surgery?

A. Same as before. I was working towards alleviating my dysphoria. I was working towards being more socially transitioned. I was working closer to getting -- to having more of a feminine look so I can be presented to the person -- presented as a person that I am. I can be around people -- like, when I want to play hobbies and sports -- I mean doing my sports

and doing my hobbies. I was working. It was a work in progress.

Q. What were some of your hobbies? You mentioned hobbies a couple of times.

A. Volleyball, baseball, and swimming.

Q. Any other non-sport hobbies?

A. I like to dance.

Q. And did you discuss the prospects of how well the next step of the process would improve your dysphoria with anyone other than Dr. Sherie?

A. No.

Q. Okay. Now, what was the recovery like for your facial portion of the surgery?

A. It was just swelling for a few weeks and then it went away.

Q. Did the recovery process, was it kind of like what they told you it would be like or was it worse?

A. Identical.

Q. Okay. Now, let's talk about the orchiectomy portion of the surgery. This was the same time; right? July 2017?

A. Uh-huh.

Q. Dr. Sherie performed this surgery?

A. Yes.

Q. It was performed in Charlotte?

A. Yes.

Q. Where were you living at this time?

A. I was staying in Jacksonville, Florida.

Q. In Jacksonville, Florida?

A. Which is Orange Park. It's all the same thing.

Q. What county is Jacksonville in again?

A. Clay County. Jacksonville? Jacksonville is Duval County. Orange Park is Clay County, but it's a suburb of Jacksonville.

Q. Okay. Gotcha.

Why did you pursue the orchiectomy?

A. I pursued the orchiectomy to have full gender reassignment surgery to have a vaginoplasty. But the first step for me was to remove the testicles due to my financial ability at that moment.

Q. Okay. So just before the orchiectomy surgery, where would you rate your -- on the 100-point scale, where would you rate your level of contentment with your -- your body matching your gender identity?

A. Where I was at that moment, I would say 8.5.

Q. Okay. Now, after the orchiectomy, where would you rate that?

A. My orchiectomy I would say decreased my scale number due to me having to come to prison, and I -- I

was -- I entered into a world that knew nothing about anything that happened to me, and everything kind of just went totally haywire from there, so it decreased my points.

Q. Okay. Just before you were incarcerated, so perhaps before -- did you plead guilty or were you tried?

A. I pled guilty.

Q. Pled guilty?

A. Uh-huh.

Q. Just before you pled and were sentenced, you had completed the orchiectomy; right?

A. Uh-huh.

Q. Where would you rate your level of contentment at that point in time before you became incarcerated?

A. I would put it at a 12.

Q. Okay. So we're at 12 out of 100 post orchiectomy but before incarceration?

A. Uh-huh.

Q. Did you discuss with anyone prior to the orchiectomy your -- your desire or hopes that the orchiectomy would alleviate your dysphoria?

A. Dr. Hope Sherie.

Q. Beyond Dr. Hope Sherie, did you speak with

anybody about this?

A. Her assistant.

Q. And at this time, were you under the care of any mental health care providers?

A. I was just seeing them as -- as needed.

Q. Who is "them"?

A. At UNC psychiatry.

Q. While you were in Florida?

A. Yes.

Q. Okay. Is this telemedicine?

A. No. I went there. I came to North Carolina sometimes weekly if not twice a week.

Q. Okay. So you were -- you were still actively going to the UNC psychiatric practice at the time that you had the orchiectomy?

A. And most of my appointments was set around my court dates. Like, if I had to be in North Carolina for court dates, if I needed to see someone.

Q. All right. What did Dr. Sherie tell you about the likelihood of the orchiectomy improving your dysphoria?

A. The first conversation Dr. Hope Sherie had with me before she did my orchiectomy was that the way she was doing my orchiectomy, she only agreed to do it if I was to continue -- she -- she did it in a manner

for which I would get a vaginoplasty next. If not, my orchiectomy would have been done a totally different way.

Q. Right. So you -- did you have any particular tissue left during the surgery?

A. She purposefully left the tissue for the vaginoplasty.

Q. And that's because that -- that's your intention is to -- that was your intention at the time, and still is, to pursue the vaginoplasty?

A. Yes.

Q. And, again, did -- did she discuss with you any -- did she provide you any information about how likely this course of surgery would help your gender dysphoria?

A. She let me know that it probably would not allieve my gender dysphoria because I was still dealing with my primary sex -- primary sex characteristics at the time. It was just basically taking the testosterone out of my body so I wouldn't have to take as much estrogen and spironolactone and progesterone. Like, it was just helping me work myself off the hormones.

Q. So the removal of the testicles allowed you to take less or different hormones?

A. Yes.

Q. Why would -- why was it necessary to -- to have the liposuction before the vaginoplasty?

A. Because you have to have -- be at a certain BMI, you have to be in good health, and my whole thing was just to remove fat from my body so I can be in the right BMI.

Q. So that was the -- the desire to -- to have liposuction at that time was --

A. Yes.

Q. -- to lower your BMI so you could proceed with the vaginoplasty?

A. Well, I was already in the area, because I was 226. The most you can be is 250. I was 226. I just wanted to be less than the 226.

Q. And why was that?

A. Because it give you more of a feminine look and not more of a masculine look if you're bigger compared if you're smaller.

Q. And so -- it's important -- is it important to you that -- that your appearance feel feminine to you with respect to your weight?

A. Very much so.

Q. And so did the orchiectomy achieve its outcomes, aside from obviously removing the testicles

which was the physical outcome, but what about the -- the outcome of alleviating your dysphoria? Did the orchiectomy provide any benefit in that regard?

A. Orchiectomy benefited removing the testosterone from my body so I wouldn't have to be on such medications. It helped with the body hair, and it definitely had a lot of cons to it.

Q. The orchiectomy did?

A. Yes.

Q. What were those?

A. Not having -- going to my next surgery and not being on the hormones caused me a lot of unwanted, like, invasive arouse. It made me gain a lot of weight, and it had made me feel like I was into, like, a hot flash moment. And then also I had a lot of stress situation about not being medically treated once I came into DPS custody because somebody never performed the physical. I never had any postoperative care, so I worried about scarring, dehiscing.

Q. What was that? Dehiscing?

A. Yeah.

Q. What's that?

A. When your surgery site comes open.

Q. Okay. How many postoperative visits did you have before you came to prison?

Q. Where would you rate your level of contentment?

A. When?

Q. Right before you were sentenced to DPS.

A. The 12.

Q. Okay. Now, you had -- you've talked about some desires for further surgery. What additional surgery are you envisioning?

A. A vulvoplasty.

Q. Vulvoplasty? And what is that compared to the vaginoplasty?

A. You do not have the vagina canal.

Q. Okay. Earlier, you mentioned vaginoplasty --

A. Uh-huh.

Q. -- as your target.

A. Uh-huh.

Q. Where does the vulvoplasty fit into that?

A. After consultation with the UNC transgender health center, I concluded that.

Q. Why -- why did you choose the vulvoplasty versus the vaginoplasty?

A. After details was given to me from DPS Terry Catlit, Katherine Croft, about DPS desire of not wanting to pay for the six months of laser surgery that it needed to have vulvoplasty -- I mean, to have a

vaginoplasty, 'cause you can't have hair growth in the testicle area -- the skin that was left on the testicle area. You had to go through electrolysis for six months.

DPS said they was not willing to pay for the electrolysis, and that DPS also stated that -- that me having dilating cones in prison was considered intrusive, provocative. So it would be kind of -- my odds of getting approval would be better for vulvoplasty than it would for vaginoplasty. And it would help alleviate my dysphoria faster instead of waiting for the process of seeing people would approve it or not approve it.

So after consultation with the nurse and the doctor at UNC, I decided a vulvoplasty.

Q. And which nurse are you referring to?

A. Katherine Croft.

Q. Which doctor are you referring?

A. Bradley Figler.

Q. Okay. So you -- you came to the conclusion to request a vulvoplasty rather than the vaginoplasty after your consultation with Dr. Figler and with Katherine Croft?

A. I did it on two different incidence. I did one in May, I made a decision of vulvoplasty, and I did

from UNC.

Q. And you mentioned -- correct me if this is incorrect -- but you mentioned, I believe, that Katherine Croft recommended the vulvoplasty to you over the vaginoplasty?

A. No. She told me the difference, and she told me what would happen with the vulvoplasty, and she told me what DPS stance was with the vaginoplasty. So after both -- and after that recommendation of both, I chose the vulvoplasty. And then when I got to Dr. Figler, he went over it with me, and his -- and the physician, he recommended the vulvoplasty.

Q. So he -- Dr. Figler recommended the vulvoplasty?

A. Uh-huh.

Q. Over the vaginoplasty?

A. Yes.

Q. Did you discuss with either of -- if you had a vulvoplasty, would you pursue a vaginoplasty later?

A. Yes. I did have that conversation. They gave me -- they told me what would happen if I chose a vulvoplasty, and if I want to have a vaginoplasty years down the road, that what the options and how it would happen. They told me exactly how it would happen.

Q. And what did they say?

A. That it would have to be robotic surgery.

Q. Did they say that that was typical?

A. They said it has been done before, but most people are satisfied, and it alleviates their dysphoria with the vulvoplasty because the primary sex characteristics isn't there anymore.

Q. So you -- so who -- who told you that?

A. This is happened -- Katherine Croft and Dr. Figler.

Q. So Katherine Croft and Dr. Figler told you that most transgender females are satisfied with just the vulvoplasty and not the vaginoplasty?

A. Right.

Q. Had you heard that from anyone else?

A. I did my own research and studies afterwards.

Q. And what did that research reveal?

A. It was very true.

Q. So is it more common, then, for transgender females to pursue vulvoplasty and not vaginoplasty?

A. There's really depends on your transition, different transitions. I mean, there's -- of 100 transgenders, there's going to be 100 different transitioning ways. So I think it's just all about what they -- their personal desire.

But their records did say, like, the research

that me and my husband and even Dr. Hahn have done, we did, said that most people are satisfied with whatever surgery they choose.

Q. Satisfied with whatever surgery they choose?

A. Yeah. Like, if they choose either vulvoplasty or vaginoplasty, that the -- the odds were that they were totally satisfied and that it alleviated their dysphoria.

Q. Okay. Now, what about the conversation in particular about being able to pursue the vaginoplasty after a vulvoplasty? You mentioned that it was -- you were told it would have to be done --

A. Robotic.

Q. -- robotically. Were you provided any information about whether pursuing a vaginoplasty after the vulvoplasty was more risky of a procedure?

A. Vulvoplasty is a riskier procedure than a vulvoplasty. Vaginoplasty is a riskier procedure than a vulvoplasty.

Q. Right. But I guess let me ask the question differently then. Were you given any information about whether pursuing a vaginoplasty after a vulvoplasty has been performed is riskier than just performing a vaginoplasty?

A. No.

Q. You weren't given any information?

A. No, because I was told during when Katherine Croft that actually robotic surgery that people normally choose if they choose five or ten years down the road is basically going -- is kind of like more like arthroscopic way.

Instead of more having to create tissue, create the vulva, create the clitoris area, because all that stuff is just created. So, basically, all they're doing is they're creating a vagina lining, like parallel to the rectum lining. So, basically, it's to have more tissue from your inner body to create the lining of it.

So it's just not -- it's a little bit more invasive having a vulvoplasty than -- I mean, to just have -- already having your vulva is kind of basically getting the hardest part out of the way.

Q. Okay. And did you discuss -- well, at the time in May, I guess, and then was it July when you met with Dr. Figler?

A. Uh-huh.

Q. In May and in July -- or let me just ask it this way. In May with Katherine Croft, when you resolved in your mind that you were going to go for the vulvoplasty, were you anticipating at a later date

pursuing a vaginoplasty as well?

A. I had no more desires. I had already made my decision that I wanted vulvoplasty.

Q. Okay. Did you -- so at that time, in May of 2021, you resolved you wanted a vulvoplasty and were not going to pursue, at a later date, the vaginoplasty?

A. Right. Prior to our going in the door, I wanted a vaginoplasty. After my consult and she explained all the details, I agreed and I left there, and that's what I decided was a vulvoplasty.

Q. All right. So --

A. And still to this day, I desire a vulvoplasty.

Q. Okay. Same set of questions for Dr. Figler's meeting, then. When you went in there and resolved that you wanted a vulvoplasty as opposed to the vaginoplasty, at that time, were you thinking that that would be it, the vulvoplasty and no other surgeries?

A. Me and Dr. Figler didn't talk about me wanting a vaginoplasty at all. We just totally focused on the vaginoplasty [sic]. And he asked me my demographics, my life surgeries, if I was circumcised, uncircumcised, like basic medical questions, and he just basically said I met the WPATH guidelines, and he recommended vulvoplasty after I had lost weight.

Q. All right. When you were discussing the vulvoplasty specifically with Dr. Figler, were you explained the risks and benefits to the surgery?

A. Yes.

Q. Were you asked to restate those?

A. What do you mean "restate" them?

Q. So Dr. Figler, I'm assuming, gave you the list of risks for the surgery. Told you what the risks were --

A. Uh-huh.

Q. -- for the surgery? Yes?

A. Yes.

Q. And same thing for the benefits to the surgery?

A. Right.

Q. Were you asked to restate your understanding of those risks and benefits to Dr. Figler?

A. Like, basically, reiterate what he just told me back to him?

Q. Right. Like repeat them in your own words?

A. No.

Q. And what was your -- who else had you talked with besides Katherine Figler -- or Katherine Croft and Dr. Figler, who else have you discussed your desire for further genital surgery with?

A. It started with Dr. Susan Garvey. It went from Dr. Susan Garvey to Dr. Joseph Granicci. It went Harnett Correctional Facility TARC. Then it went to divisional TARC when Dr. Junker was over it. And then after that, I spoke with Dr. Yow -- I mean You, yeah, You -- Dr. Yow, Y-o-u -- Y-o-w, sorry, at UNC endocrinology about it.

I spoke to Ms. Fields, Ms. Harvey -- Dr. Harvey. I spoke to Ms. Norris here, Ms. Baker, Dr. Hahn, and Mr. Messer. And I could be missing some people.

Q. And these people you just listed, are these -- these are all either nurse practitioners, nurses, doctors, and psychologists with DPS?

A. And outside of DPS at UNC as well.

Q. And what is your -- what's your purpose in seeking out -- what are you hoping to achieve by having the vulvoplasty?

A. To alleviate my gender dysphoria and that my secondary character -- my secondary characteristics will align with my body.

Q. And who -- who were you -- who did you discuss the -- the objective of alleviating your dysphoria with?

A. Every last one of the ones I just named

before.

Q. Okay. Did anyone provide you with any information about how likely it is or would be that the vulvoplasty would alleviate your dysphoria?

A. Neither one of them actually went in details about vulvoplasty or vaginoplasty, they just totally said "gender-affirming surgery."

Q. Who -- who is "they"?

A. Even the ones who had submitted the ERs compared to the specialist and providers I seen at UNC, DPS. It was -- it didn't go into the actually vulvoplasty until after 2000 -- July of 2021. Prior to that, the doctors was all talking to me about the vaginoplasty.

Q. Did you have any conversations with Dr. Figler about whether the vulvoplasty would improve your gender dysphoria?

A. Yes.

Q. What were those conversations?

A. He said that it will alleviate my gender dysphoria.

Q. And what did you understand that to mean?

A. That mean that I would be -- finally be healed.

Q. Okay. And healed as in cured or healed as in

improved?

A. No more mental and emotional distress and anguish.

Q. Okay. Did you have conversations with Katherine Croft about the prospects of the vulvoplasty improving your gender dysphoria?

A. Yes. She very much identified because she's trans female as well.

Q. Okay. And tell me about your conversation with Dr. Ettner. Did she -- did you speak with her about the prospects of the vulvoplasty improving your gender dysphoria?

A. Yes.

Q. What were those conversations?

A. She basically asked me why did I want it. She asked me to what was her understanding about it. How she had treated people before her experience. Her history with it. What I was going through in life. How I felt that would make my alleviation better. And based off the WPATH standards of care, basically what the DSM-5 says. That's totally -- all kinds of things. How it will totally alleviate my gender dysphoria.

Q. Okay. So you said "totally alleviate." Do you know if -- did Dr. Ettner ever tell you that the surgery -- the vulvoplasty would cure your gender

dysphoria?

A. I don't know there's such thing as curing gender dysphoria. I think it alleviates it.

Q. Okay. Is there a difference between totally alleviating and curing?

A. Yes, I think so. In my understanding, it would be.

Q. Okay. So, then, what is your understanding of the likelihood of the vulvoplasty curing your gender dysphoria?

A. I don't feel like a cure because I feel gender dysphoria isn't a disease, and I feel like diseases are cured. And I feel that my gender dysphoria would be alleviated because it's -- like right now, it's acutely high.

That me having surgery will alleviate my gender dysphoria, because it will align my body with my character -- my sex characteristics, and it will emotionally stabilize me. It will mentally make me feel better. It will discontinue my feelings of seeing myself when my clothes is off and not feeling to complete, like I went all over those details with you, how it would make me feel once I have surgery.

Q. Okay. So I understand you take issue with the phrase "cure" because you don't view gender

dysphoria as a condition; is that right?

MS. MAFFETORE: Object to the form. Mischaracterizing her testimony.

BY MR. RODRIGUEZ:

Q. Recharacterize it for me.

A. I don't look at gender dysphoria as a disease, and I feel like disease are cured, and I feel like my dysphoria has to be alleviated --

Q. Okay.

A. -- not cured.

Q. Fair enough.

A. Yes.

Q. So do you think that the vulvoplasty would eliminate your gender dysphoria?

A. I say alleviate, not eliminate.

Q. Okay. So back to that 100-point scale. After the vulvoplasty, which you say is the last surgery, correct --

A. Uh-huh.

Q. -- that you're going to seek?

So after this final genital surgery, where would you anticipate your level of contentment being?

MS. MAFFETORE: Object to the form. Calls for speculation.

/////

BY MR. RODRIGUEZ:

Q. You can answer.

MS. MAFFETORE: You can answer.

THE WITNESS: I would say probably about 95 percent because I'm going to have continuous care, meaning psychotherapy for the remainder of my life, and I feel that that psychotherapy will take care of the 5 percent.

BY MR. RODRIGUEZ:

Q. Okay. So your hope is that the vulvoplasty will bring you from under 12 because --

A. Uh-huh.

Q. -- you were at 12 before we came through the fence; right?

A. Uh-huh.

Q. And then it went down. So your hope is that the -- the vulvoplasty will bring you from, I don't know, 10? What would you say your contentment was when you came into prison?

A. I'd definitely say about a 10, and it would carry me to about 95.

Q. And the basis for that understanding is what?

A. Can you rephrase it?

Q. The basis -- why is it that you think that the vulvoplasty or how is it that you think the

vulvoplasty will alleviate your dysphoria such that your level of contentment goes from a 10 to a 95?

A. Because it takes away my primary sex characteristics, which alleviates my gender dysphoria on an emotional and a mental level. It takes that totally away. And it's replaces it with a secondary, which makes me to be in line with the female that I am.

Q. And have you discussed that understanding and -- and -- and hope with other people?

A. I have even explained it all the way to Governor Cooper.

Q. Have you discussed this with -- I'm assuming with Dr. Ettner?

A. Dr. Ettner, DPS psychiatrist, DPS psychologist, UNC specialists, DPS social workers, DPS unit managers, ACLU lawyers, everyone.

THE VIDEOGRAPHER: You've got about ten minutes on this tape.

MR. RODRIGUEZ: Yeah. Let's break now. That's a good stopping point.

THE VIDEOGRAPHER: The time on the monitor is 11:48 a.m. We are off the record.

(Whereupon a lunch recess was taken.)

THE VIDEOGRAPHER: The time on the monitor is 12:45 p.m. We are back on the record.

BY MR. RODRIGUEZ:

Q. Okay. So I want to circle back on a couple of -- a couple of things that I -- that I missed that I neglected to ask earlier in our conversation.

But is your -- your mother and father, are they still alive?

A. My mother is deceased and my father is alive.

Q. And when did your mom pass away?

A. 2011.

Q. 2011?

A. Uh-huh.

Q. Okay. How did she pass away?

A. Cancer.

Q. When did your father pass away?

A. My father isn't passed.

Q. Oh, I'm sorry. Where does your father live now?

A. He is either in Wilson County or Wayne County. Not for sure which county it is.

Q. Okay. And you mentioned some issues related to hormone therapy upon incarceration, perhaps being interrupted or something to that effect. Do you remember testimony about that? Not getting a physical or something?

A. Yes.

Q. Can you tell me a little bit more about that?
A. I didn't get a postoperative exam until last month after being in prison for five years.
Q. You didn't get a postoperative exam for --
A. I didn't -- no. Nobody ever examined me.
Q. Examined which part of you?
A. My orchiectomy site.
Q. Okay. So you --
A. And I did my dressings myself when I was at Harnett Correctional.
Q. So no one examined -- physically examined your orchiectomy -- the site of your orchiectomy until last month?
A. Yes. And that was by Nurse Practitioner Brittany Baker.
Q. And what about the -- when you entered custody in October 2017, were you on hormones?
A. Yes, I was.
Q. And did you have any issues related to your hormone treatment upon entering DPS custody?
A. Yes, they stopped it.
Q. Okay. And what was your understanding about that?
A. That it had to be approved.
Q. Okay. Can you talk a little bit about the

process for that?

A. Said that it had to go through a facility TARC. Then it has to be approved through the DTARC and, ultimately, eight months after my incarceration started in June of 2018.

Q. Okay. So there was an eight-month period from when you were incarcerated until you started receiving your hormones?

A. Yes, sir.

Q. And during that period of time, how did you feel?

A. I felt really bad. I was having real bad hot flashes. I was having arousals. I was having feeling of feeling like I was having, like, some joint type of issues like in my back. And I was just really moody. I can tell that I was off hormones.

Q. Okay. And so did you believe that -- that all those things you just listed were related to the lack of hormones?

A. Yes.

Q. Did you discuss those issues with any -- any medical providers?

A. Yes.

Q. Which ones?

A. Dr. Joseph Yunessy and Nurse Brian Crawley.

Q. And after about eight months when you resumed the hormone therapy, did those issues resolve?

A. No, not immediately.

Q. Did they eventually resolve?

A. No, they didn't.

Q. So you still experience those problems?

A. I have an issue with DPS not following up with my scheduled maintenances and not doing labs when they supposed to. So when the endocrinologist may say I suppose to take something for three months, DPS end up having it on me for six months. Where like one time it was a whole year. So the management of my hormones are not adequate.

Q. Okay. And so what sort of, first, physical impacts do you feel are associated with what you contend are the inadequate management of your hormones?

A. No. 1 is the -- the emotional effect of it, where it causes you to be very emotional. Second aspect would be where it comes from like the hot flashes feeling like I'm in menopause.

The second part of it's knowing that my body have no hormones whatsoever by the removal of my testosterone. My body needs some type of hormone. And knowing that my body has nothing in it, it mentally mess with me knowing that my body lacks no kind of

hormones in it.

Q. So after you started the hormones in -- in eight months after becoming incarcerated, so that's June 2018?

A. Uh-huh.

Q. After June 2018, have you gone periods of time without any hormones?

A. Yes.

Q. How -- how many times has that happened?

A. Over three. I don't remember the number, but it's over three.

Q. More than five?

A. I would say between three and five.

Q. Okay. And for how long of a period of time in each of those instances would you go without hormones?

A. Without hormones? I have been without it for a two-week period.

Q. Is that the longest?

A. I think that was the longest.

Q. Okay. So aside from those three to five instances when you didn't have hormones for at most two weeks, have you had hormones in your system?

A. I have had hormones in my system, yes.

Q. Okay. And so, is your contention, then, that

the management of those hormones has not been appropriate?

A. Yes.

Q. And that's based off of what?

A. Based off of what the endocrinologist recommend, and during his follow-up and consult with me to tell me how they should be managing and how much I suppose to get and when I suppose to get them.

Q. And which -- which medication in particular has been mismanaged?

A. The estradiol.

Q. Estradiol?

A. Uh-huh.

Q. And how do you ingest that medication?

A. Intramuscle injection.

Q. So it's a -- it's a -- it's a needle injection?

A. Yes.

Q. Have you had a patch?

A. I have had a patch.

Q. So what's been the -- what's your understanding of the issue regarding the dosage of the estradiol?

A. One of the issues was that the doctor wanted me to have 0.5, and the medical was giving me -- was

giving me 1. Instead of 0.5, they was giving me .5 more.

Q. And when did that happen?

A. That happened this year. It happened for a period of about six months this year.

Q. That you got too much estradiol?

A. Yeah. And it was notated into the Hero (phonetic). And I didn't even know it. I didn't know that I was getting that much. And then Dr. Caraccio (phonetic) noticed it at my follow-up in August that I was getting 1 -- 1.0 instead of the 0.5.

Q. Okay. And that was this past August you said?

A. Yes.

Q. And -- okay. So setting aside that incident, what other incidents have you had with dosing and hormones?

A. Not getting labs when I'm supposed to to show my lab levels. It got so high one time where the Lab Corp people called here to the prison, and it was kind of listed that I was -- my hormones was being still read and they're a male gender and not a female gender. And it also showed that my hormone level was not in the range where he wanted it to be within 200. It was lower than the target range that he was trying to get

to.

Q. And was that an issue with dosing?

A. I think that was an issue with not following up so he can up the dose to get it to where it needed to be.

Q. Okay. So aside from the issue with getting the 1.0 instead of the .5, do you know of any instances where you were provided what you believe to be the incorrect dose of medication?

A. No.

Q. You alluded earlier to a period of separation perhaps with your husband?

A. Uh-huh.

Q. Did I -- is that accurate?

A. Yes, it's accurate.

Q. Okay. Are you presently separated from your husband?

A. No.

Q. Have you been in the past separated from your husband?

A. I was only staying in a totally different house. So that was the only type of separation that we had. I was staying in one -- in one state, and he was staying in another state.

Q. And when was that?

A. And that was prior to my incarceration. About six months prior to my incarceration.

Q. Okay. So that would have been early --

A. 2000 --

Q. -- 2017?

A. Yes.

Q. And where were you living at that time?

A. Orange Park, Florida.

Q. And where was Mr. Brown living?

A. In North Carolina.

Q. And why were you all separated?

A. I was waiting to go to court, and I was staying there, and that's where my bond was posted at. I mean, not my bond was posted -- my bails bond, they had my address there; so I stayed there.

Q. And so that -- that wasn't a consequence of your relationship with Mr. Brown; that was a logistical issue?

A. Yeah, it was logistic.

Q. And I notice you have various tattoos.

A. Uh-huh.

Q. Tell me about some of those tattoos. When you received them, and what they -- what they mean to you.

A. My tattoos is my form of expressing myself.

It's a form of art. And I have been getting them since early 2000s.

Q. Have you received any tattoos since you have been incarcerated?

A. No, I have not.

Q. Do any of the tattoos have any special significance to you?

A. Every last one of them have special significance.

Q. Any you care to share?

A. No.

Q. Have any of the tattoos that you have, do any of them relate to your struggle with gender dysphoria?

A. A lot of them.

Q. Can you elaborate?

A. It expresses what I go through. Like, it shows expression of the pain. It shows the expressions of how gender dysphoria is hard for me. It's just an expression of it.

Q. Okay. I want to circle back briefly before we continue our chronological conversation to your -- your consultation with Dr. Ettner. How many times have you met Dr. Ettner?

A. Once in person and once over the phone.

Q. Okay. When was the first time you spoke with

Dr. Ettner? Was it over the phone or in person?

A. In person.

Q. And when was that?

A. That was -- I want to say maybe -- I don't remember.

Q. Was it 2022?

A. Yes, beginning of this year.

Q. And do you recall how long that in-person meeting was?

A. I want to say it was three hours.

Q. And what about the phone call with Dr. Ettner? That was after the in-person meeting?

A. Yes.

Q. How long was that phone call?

A. An hour.

Q. An hour?

A. (Witness nods head.)

Q. So aside from those two instances, have you communicated with Dr. Ettner at all?

A. No.

Q. And what did you discuss with Dr. Ettner?

A. My gender dysphoria, my current feeling, my current mental state, what I have been through in my past, my past histories, my demographics, my family, my relationships, my education, my entire life story.

Q. Did you discuss your desire for a vulvoplasty with Dr. Ettner?

A. Yes, I did.

Q. And did you discuss your hopes that the vulvoplasty would alleviate your gender dysphoria?

A. Yes, I did.

Q. And what did she tell you -- what did Dr. Ettner tell you about the prospects of the vulvoplasty alleviating your dysphoria?

A. Based off her experience and the guidance from many associations, that it will alleviate my gender dysphoria.

Q. Did she tell you -- talk about with you whether you would experience any distress related to misgendering or transphobia post vulvoplasty?

A. No, I have always -- only time I have all -- publicly identified as transgender is when I had to when DPS publicly identified me as transgender in prison. Besides that, I don't prefer to be publicly identified as transgender. I'd just like to be publicly identified as a woman.

Q. Did you have any discussions with Dr. Ettner about the possibility that even post vulvoplasty you might still experience some afflictive emotions related to your transgender status?

A. Based off of what I have been told by Dr. Ettner is that emotions is something that's going to come from my hormones, not from my surgery.

Q. Okay. So did Dr. Ettner offer any insight as to how surgery then would alleviate your dysphoria if your emotions are tied to your hormones?

A. Surgery allieves dysphoria based off -- 'cause it eliminates the primary sex characteristics, and it gives me secondary characteristics to align with my genders -- I mean, to align with who I am as a female and to help alleviate my gender dysphoria.

Q. Okay. The vulvoplasty would not remove any -- it would -- the vulvoplasty would remove the -- the tissue of the penis; correct?

A. Vulvoplasty removes the -- yeah, the inner of the, but the remainder is used.

Q. Okay. And do you understand -- do you know whether vulvoplasty has any impact physiologically on someone's hormones?

A. It definitely would not.

Q. You mentioned earlier that you had done some -- some research, I think specifically related to patient satisfaction perhaps regarding vulvoplasty or vaginoplasty. Tell me a little bit more about that research you conducted.

A. The research is done with myself and Dr. Hahn and myself and Mrs. Dula.

Q. Mrs. --

(Clarification by the reporter.)

THE WITNESS: Dula, D-u-l-a.

BY MR. RODRIGUEZ:

Q. And who's Ms. Dula?

A. Jennifer Dula was a licensed clinical social worker assigned to my therapy here at Anson.

Q. Assigned through your therapist?

A. She was assigned as my therapist.

Q. How many therapy sessions did you have with Jennifer Dula?

A. Every 14 days, numerous.

Q. How -- how long of a period of time do you think?

A. Over maybe close to a year.

Q. So biweekly for about a year?

A. Yes.

Q. And at that time was she your only mental healthcare provider?

A. At the beginning, no, her and Dr. Hahn.

Q. Okay. Was this around the time Dr. Hahn retired?

A. Yes. This was all the way up until June of

2021.

Q. And so when you say you conducted this research with Dr. Hahn and Ms. Dula, where -- where did you -- how did you guys do this research?

A. They did it online.

Q. Okay. Were you with them when they researched it?

A. Yes. I was in the therapy session with them.

Q. You were what?

A. In the therapy session with them.

Q. Okay. So the three of you all conducted research during your therapy sessions?

A. It wasn't all three of us. It was -- I was with Dr. Hahn sometimes, and I was with Ms. Dula on other times.

Q. Okay. So you never had any joint sessions with the two of them?

A. No.

Q. Okay.

A. Well, Ms. Dula sat in one time to get her -- trying, I guess, to get like a rapport of what was going on with me after reading my medical records, but it was very brief, like maybe ten minutes, and then she left out of the therapy session, and Dr. Hahn continued.

Q. Okay. And what is, then -- well, do you know what websites or research tools were used to conduct this research?

A. No. I did not see the computer.

Q. Did you read any of the actual research yourself?

A. Yes. I read some of the papers that they printed off.

Q. Did you discuss the research with Dula or Dr. Hahn?

A. Yes.

Q. What was some of the research that you remember reading?

A. Actually showed a diagram of step-by-step process of how it happens.

Q. How the surgery happen -- how the vulvoplasty happens?

A. Yes. It actually told me how the satisfaction of trans women that have been through gender-affirming surgery, how they feel post at certain, like, six months, one year, three years, five years. Told me about how some of them may feel when it come to down to being on hormones, if they want to continue hormones, not continue hormones.

Q. Post surgery?

A. Yes, post surgery. And then just all around basically their review of it.

Q. So I think you said earlier that the vulvoplasty would not impact hormone levels; correct?

A. No. 'Cause I don't have testosterone in my body. My testicles has already been removed, so vulvoplasty wouldn't affect that because it's already been affected.

Q. So what's your understanding, then, of whether you would want to continue on hormones post vulvoplasty?

A. I want to -- to continue at a decreased level of hormones, which I'm trying to do currently, but I can't get to the doctor.

Q. And you can -- you can decrease your hormone levels without a vulvoplasty?

A. You don't have to be on hormones ever again if you don't want to if -- after you have testosterone -- after you have your testicles removed and have a orchiectomy. That's a choice.

Q. Okay.

A. Some people do; some people don't.

Q. Right. So, then, is your decision to -- to either stay on hormones or change your hormones level, is that contingent at all on the vulvoplasty?

A. No. Hormones and vulvoplasty are two different things. My hormone I want to stay on them for still the -- the breast tissue, the softening of the skin, you know, to have the effects that it does.

My vulvoplasty is to relieve me of my gender -- alleviate my gender dysphoria for me to feel better because I won't have that primary sex characteristic no more.

Q. And that's the penis that you're referring to?

A. Yes. I prefer to call it a phallus.

Q. A what?

A. A phallus.

Q. A phallus. Okay.

The research that you reviewed and discussed with Dula and Dr. Hahn, what's your understanding of what that medical research says about the potential for a vulvoplasty to alleviate the mental distress that may be associated with gender dysphoria?

A. After -- when we did research based off of numerous associations like the Psychiatric Association, Sociology Association -- I mean, not sociology -- Psychologist Association, the WPATH, the American Medical Associations, that according to them, it alleviates gender dysphoria for trans females.

Q. Had you been aware of that research in general before you did the research with Hahn and Dula?

A. Yes. I did it myself as well before I came to prison.

Q. Oh, you did?

A. Uh-huh.

Q. Tell me about how did you that research before you came to prison.

A. I talked about it in my therapy sessions at UNC. I did it over the phone, like, look it up on Google and different transgender sites. Look at videos of numerous of trans females on YouTube that documented their recoveries and their transition post. Different ways.

Q. So you discussed your hopes that the vulvoplasty would alleviate your gender dysphoria with folks at UNC psychiatry?

A. I had spoke to them about it, yes.

Q. Okay.

A. And I don't think I actually would say "vulvoplasty." It was gender-affirming surgery that I would say anything. I don't think I said "vulvoplasty." It's like gender-affirming surgery.

Q. And what's your understanding of what that means, gender-affirming surgeries?

A. It affirms your gender.
Q. Right. Does that -- well, okay. What procedures are included in that category?
A. It all depends on the person's transition.
Q. Okay. Would -- would all the surgeries you -- that we already discussed qualify as gender-affirming surgeries?
A. Rephrase.
Q. Okay. I'll just do one at time. The breast augmentation, is that gender-affirming surgery?
A. That's -- yes.
Q. Okay. What about the earlobe surgery?
A. Yes.
Q. The facial feminization surgery?
A. Yes.
Q. The -- the Brazilian butt lift? I can't remember the name.
A. Yes.
Q. Okay. What about some of the surgeries you -- procedures you haven't had done, the liposuction of the abdomen?
A. Yes.
Q. That would be gender-affirming surgery?
A. Yes.
Q. Are there other surgical interventions that

you are aware of that you would consider gender-affirming surgery?

A. I think it all depends on the person that's transition, what they consider is gender-affirming surgery to them.

Q. And so when you were conducting this research, then, before you came into prison, so pre-October 2017, when you were looking into research about how effective surgery would be for improving gender dysphoria, that research was not specifically focused on vulvoplasty?

A. I don't remember.

Q. Okay. It was more broadly focused on gender-affirming surgeries categorically?

A. Yes.

Q. To include the various types of surgeries we discussed?

A. Yes.

Q. So you don't have -- do you have any specific recollection of reviewing on your own before you came into prison any medical literature regarding the effectiveness of vulvoplasty or vaginoplasty in alleviating gender dysphoria?

A. Vaginoplasty.

Q. Vaginoplasty?

A. Yes.
Q. You do recall --
A. Uh-huh.
Q. -- reviewing studies that discussed the effectiveness of vaginoplasty in alleviating symptoms of gender dysphoria?
A. Yes.
Q. Do you remember what those studies said?
A. That it allieves gender dysphoria.
Q. Completely alleviates or improves?
A. I don't believe -- I don't even believe I would be completely alleviated, so I don't say -- I would not say that it said it would be completely alleviated, because I wouldn't be completely alleviated.
Q. That's the 95 versus the 100; right?
A. Yes.
Q. So then -- okay. And that was literature you reviewed before coming to prison?
A. Yes.
Q. And what about the literature that you reviewed with Dr. Hahn and Jennifer Dula? Do you remember discussing or seeing any literature that specifically dealt with the effectiveness of vulvoplasty or vaginoplasty in alleviating gender

dysphoria?

A. Vulvoplasty because that was totally what we was researching.

Q. Okay. So pre-incarceration you recall seeing studies that discussed the effectiveness of vaginoplasty in alleviating gender dysphoria. Post-incarceration, Dr. Hahn and Jennifer Dula and you recall seeing studies that discussed the effectiveness of vulvoplasty in alleviating gender dysphoria. Is that your testimony?

A. Yes.

Q. All right. Beyond -- would you -- would you seek out a vaginoplasty after you had a vulvoplasty?

A. I don't have that desire.

Q. Okay. So vaginoplasty is off the table?

A. Yes.

Q. Beyond vaginoplasty, are there any other surgical procedures that you would anticipate undergoing, irrespective of your being incarcerated? If you were out in the free world, what other surgical procedures would you pursue?

A. If I was home, I will definitely start with veneers. I will get liposuction. I will possibly consider having a rib removed. And I will contour my waistline.

Q. Okay. Veneers, is that for teeth?

A. Yes.

Q. And why would you pursue veneers?

A. 'Cause it would give me more of a feminine smile when I smile.

Q. And how would that -- how would you anticipate that would improve your -- what affect do you think that would have on your well-being?

A. It helps a lot because it will make me feel more satisfying. It will satisfy my look that I'm achieving -- trying to achieve.

Q. And is -- is the look that you're trying to achieve, is that the -- does that impact your dysphoria?

A. I feel that veneers wouldn't impact my dysphoria. It's not something that will help alleviate it or increase it. So, no, that is just a -- an answer to your question like what things I would pursue if I was out of prison.

Q. Right. But the -- the look, trying to achieve a particular look, is -- is not looking a certain way, does that affect your dysphoria?

A. The look that I have currently has alleviated my dysphoria with look wise.

Q. Okay.

A. I don't seek no other surgery to enhance my look --

Q. Okay.

A. -- for dysphoria.

Q. For dysphoria?

A. Yes.

Q. Okay. So, then, what -- does that include the vulvoplasty?

A. That -- that has to do with my facial look. My vulvoplasty definitely has to be done because it will alleviate my gender dysphoria by removing my primary sex characteristics.

Q. Okay. Okay. So what -- what drives your dysphoria? What do you think fuels your feelings of dissatisfaction?

A. Not -- my sex not being aligned with the woman that I am. That I'm still dealing with the sex at birth.

Q. And so what things have helped you align that look?

A. My medical transitions.

Q. And so changing the way that you look, whether it be through the breast augmentation or the vulvoplasty, that has helped your dysphoria because it's moved you closer to the way you want to look?

A. Yes.

Q. Okay. And the same thing with the Brazilian butt lift, the narrower hips and -- and whatnot, those improvements in your -- in your look, from your perspective, have improved your dysphoria?

A. Yes.

Q. But veneers, that's not a -- would that be a gender-affirming procedure?

A. No.

Q. And why would that not be?

A. It's just for me to have a different smile, for me to feel more -- like, more happier with myself. Make me feel more feminine with myself. Like, it makes me -- if I smile, I just know I have pretty teeth.

Q. And -- and having a more feminine smile, that would -- would that be helpful for your dysphoria?

A. I am satisfied with my look as being a female that I am as far as my dysphoria.

Q. Your facial look?

A. Yes.

Q. So we said veneers. You mentioned liposuction as an additional surgical procedure?

A. Yes.

Q. Where would you have liposuction performed?

A. I would perform it on my stomach, my back,

A. That's very common for trans females to have a rib removed to have a smaller waistline.

Q. Okay. So there's an aesthetic result for that too?

A. Yes.

Q. Okay. And why would you -- you would do it for a smaller waistline?

A. Yes.

Q. And why is a smaller waistline important to you?

A. Also a more enhanced, feminine look.

Q. And a more enhanced, feminine look -- feminine look is a goal of yours because if you -- if you look more like how you want to look as a woman, it eases your dysphoria?

A. Yes.

Q. And were there any other -- the -- the liposuction, the ribs, and the veneers, were those the only additional surgical procedures you would undertake?

A. That's it.

Q. Okay. What about nonsurgical treatments or procedures? In the free world, if you had your choice to pursue, what would -- what would those be?

A. A decrease in hormones.

Q. Do you not have the ability to take less hormones?

A. Evidently, I don't here in prison because it's not happening.

Q. Okay. So a desire to decrease the amount of hormones you're taking?

A. Yes.

Q. How many hormones do you take? Just one or two?

A. I take them -- hormones every 14 days, 0.5 ML every 14 days, which equate to about 20 ML a month.

Q. Is it one -- one -- one medication, though?

A. Yes, just one.

Q. Just estradiol?

A. Uh-huh.

Q. And so you want to take less of that, or you want to stop taking it?

A. No, I would prefer to take less.

Q. Take less. Okay. And have you told your providers in DPS that you want to take less estradiol?

A. I total of five times since August.

Q. Okay. And their response to you was what?

A. I have not got to the endocrinologist when I suppose to have gotten to him in November, and it's January, and I still haven't made it there yet.

Q. Okay. So nobody has told you that you can't take less?

A. It was denied to go to the endocrinologist. You are disapproved it.

Q. Right. To go -- to go visit with the endocrinologists?

A. Yes.

Q. But no one has denied your request to take less hormones, have they?

A. They did deny. That was my whole reason of going to the endocrinologist to get less hormones, and they denied it.

Q. Okay. So they said that they're not sending you on a trip to go see Dr. --

A. Amos was the person who said it.

MS. MAFFETORE: Let him finish his question.

THE WITNESS: Okay.

BY MR. RODRIGUEZ:

Q. All right. So less hormones. You want to take less hormones. What other nonsurgical procedures would you want to pursue?

A. None.

Q. What about laser hair removal?

A. Yes.

Q. Okay.

A. But that's a surgical procedure.
Q. Is it? Okay.
A. It was denied in here.
Q. Okay. So that is a surgical -- you would consider that to be a --
A. Yes.
Q. Okay. So tell me about laser hair removal.
A. I started it in Corpus Christi, Texas. And when I came to prison, part of my hair on this side and this side started to come back.
Q. And how did -- how does the presence of hair on your face affect you?
A. Because a female don't have hair on their face.
Q. Okay. All right. So you -- so you'd done laser hair removal in the past. And the purpose of that, I presume, was to remove the hair; right?
A. Yes.
Q. And why -- and you wanted to remove the hair because, as you said, females don't have hair on their face. And so was that an effort to make your appearance align more closely with what you envision a female to look like?
A. Yes.
Q. And is that an effort -- does that alleviate

your dysphoria?

A. Yes.

Q. Okay. So you would -- you would continue, or you would pursue additional laser hair removal?

A. Yes.

Q. And -- and just of the facial area?

A. Yes.

Q. And have you discussed with anybody the effectiveness of laser hair removal alleviating symptoms of gender dysphoria? Not removing the hair. Let's assume that it's 100 percent effective at removing the hair, but have you discussed with anyone of the likelihood that your gender dysphoria symptoms would be substantially lessened if you had laser hair removal?

A. Yes.

Q. Who did you discuss that with?

A. The facility TARC here at Anson, Ms. Dula, Dr. Bowman, Ms. Foster, and Dr. Housen (phonetic).

Q. And what is your understanding of whether laser hair removal would lessen your symptoms of gender dysphoria?

A. You don't have to shave every day to be reminded that you were assigned a male at birth. It's gone; you don't have to worry about it.

Q. Are you aware of any medical literature addressing the effectiveness of laser hair removal in alleviating the emotional symptoms of gender dysphoria?

A. Yes.

Q. What does that literature say?

A. That it helps alleviate gender dysphoria in trans women. It was given to me by UNC endocrinologist.

Q. Okay. So beyond the laser hair removal, which is a -- you would put that in the surgical bucket; right? So beyond the laser hair removal and then the -- the rib and the veneers and the liposuction, any other surgical -- what you would consider to be surgical interventions that you would pursue?

A. No.

Q. So if you had all -- okay. And then any other nonsurgical interventions?

A. No.

Q. So if you had all of these interventions that we've discussed, the vulvoplasty, the ribs, the veneer -- or the rib, the veneers, the liposuction, the laser hair removal, what would your -- what would you anticipate your level of contentment to be on a scale of 1 to 100?

A. That includes vulvoplasty?
Q. Everything.
A. Ninety-five.
Q. Ninety-five. And where is that other 5 percent coming from?
A. Psychotherapy.
Q. And -- and what if -- so what -- what efforts, then, would you take to alleviate distress after you had all these interventions?
A. Therapy.
Q. Therapy. Any other mitigation efforts beyond that?
A. Professionally?
Q. Uh-huh.
A. Just therapy.
Q. What about nonprofessionally?
A. Sport, dancing, enjoying my hobbies, vacationing, yeah.
Q. And so has anyone ever forecast to you that possibility that even after various interventions, some folks still experience significant symptoms of gender dysphoria?
A. Not to my knowledge.
Q. Okay. So your understanding is that if you had -- were able to have all of these procedures, you

would be at 95 percent?

A. And I say 95 because I will always, continuously need therapy for the remainder of my life from all of the drama that I have experienced. So that will 100 percent complete me as long as I have my therapy.

Q. And what if the surgeries only got you to 70 percent?

A. I don't foresee that.

Q. But have you -- have you discussed the possibility -- that possibility with anybody?

A. I don't feel like I can discuss something that's not going to happen. I only discuss things that will happen. I don't see why surgery will only get my dysphoria to 70 percent.

Q. And -- and -- and the key to that, that breakthrough, is through the vulvoplasty. That's the one that's bringing you from 10 to 95; correct?

A. Yes.

Q. So if the vulvoplasty brings you from 10 to 95, what are the -- what are -- the other treatments don't -- don't aid?

A. Which other treatments?

Q. The ones post vulvoplasty. Laser hair removal, the ribs, the veneers, the liposuction.

A. Those are just more things that you asked that I will do if I was home, like if I had a desire. It's not something that has to be done. It's something that would be deemed elective to me. Like something that I just elect to have it done if I'm financially able to do it.

Q. So you would consider the liposuction to be an elective procedure?

A. I would consider it to be something if I -- if I needed it done later -- at a later time, I can elect to have it done then when I feel like it. But it doesn't -- if it never happens, it does has no bearing on me, not my gender dysphoria being like through the roof. Like, it's -- it's nothing compared to a vulvoplasty.

Q. All right. So let's talk about your time before October 2017. How would you describe your mental well-being at that time? In general, before you came to prison in October 2017, how would you describe your mental health?

MS. MAFFETORE: Object to the form. Vague. Before 2017 --

MR. RODRIGUEZ: Okay. We can do it this way.

BY MR. RODRIGUEZ:

Q. In the period of time between your

A. Yes.
Q. Before you started therapy in 2010, then, were you -- describe the kind of distress that you felt by feeling this misalignment.
A. I feel like I just told you that, but ...
Q. Okay. I'll ask some different questions, then.
A. Yes.
Q. So we walked through your employment history --
A. Yes.
Q. -- right? And your educational history.
A. Uh-huh.
Q. On a Tuesday when it was time to get up and go to work, how did you feel in relation to having to go about your daily activities and responsibilities? How did the -- what you later learned to be gender dysphoria, how did that impact your life?
A. It impact it because I had to put pads on to make my -- have a butt, hips. I had to put silicone -- fake silicone boobs on to fill my bra. I had to make sure that my makeup looked a certain way to have a presentation of a female. That's very stressful.
Q. Okay. Did you have trouble sleeping?
A. No.

Q. When you say it's "stressful," was it -- was it stressful in the sense that you felt like you had to do all of these things like you mentioned, the pads and the bras and the makeup and hair, in order to appear more feminine? Was that the stress that you were feeling?

A. It's the stress of me not understanding what gender dysphoria was, and just gender dysphoria gives you stress and anxiety of having to live your life as the person you was born compared to the person you're trying to align yourself to be. It causes like stress and anxiety.

Q. When you were employed, when you would show up to work, did you -- did you show up to work with the hair and the makeup the way you wanted it to look to present the way you wanted to present?

A. To a certain degree, because I was still -- at the beginning, still having the name of [redacted] [redacted] So to a certain degree, I -- I would appear feminine, but I appeared myself as more feminine queer than I did as a transgender woman.

Q. Okay. And did you feel like you were limited in your ability to present how you wanted to present?

A. I was -- yes. I felt very limited, yes.

Q. By what?

A. I felt limited what I could do and how I can do it, because I didn't know how to deal or how to attack gender dysphoria because I didn't know what it was yet.

Q. Okay. So were you -- were you doing the hair and the makeup and the pads and all that stuff before you put a name to gender dysphoria?

A. Yes.

Q. And when you were able to express yourself or present the way that you wanted to present without a limitation, how did you feel? Did you feel sad about that?

A. Sad about putting the pads and stuff on?

Q. Right.

A. It made me feel better in the moment. It made me feel in the moment, like, good for the moment, but still knowing that, you know, I'm not who I think I -- mentally know I am. I know I'm not who I am. Or if I have to take my clothes off or have to wear certain things, you know, it does trigger, like, the distress and everything, more anxiety.

Q. So when -- describe how you -- how you felt when you felt anxious, when it would trigger the kind of anxiety you just mentioned.

A. Sweat.

Q. You would sweat?

A. Yes.

Q. Did you have trouble sleeping?

A. No.

Q. Did you have panic attacks?

A. I am known to have a few panic attacks, yes.

Q. Did you have any periods of depression?

A. If I did, I didn't know how to identify it.

Q. Were there any periods of time where you couldn't go to work, couldn't get out of bed because you were so upset over having this sort of incongruence between the way you wanted to be and how you felt you were?

A. No.

Q. Did you ever take any -- before being incarcerated, any medication for anxiety or depression?

A. No.

Q. Did you ever feel sad about feeling the way you felt?

A. No.

Q. So, then, on a -- on a scale of 0 to -- 0 to 10 or 0 to 100, whichever you would prefer, then, say in the 12 months before your incarceration, how would you rate your general level of stress, not specific to gender dysphoria, just in general?

up?

A. It happened in 2012. October 2012.

Q. Oh, okay. So you had the -- those charges that you were incarcerated in 2017 were from 2012?

A. It took five years for me to get to court.

Q. Okay. All right. Well, then, it's pretty hard to parse that out, then, isn't it?

A. Yes.

Q. So then tell me in general, then, about your level of stress -- we can go year by year if you'd like -- your level of stress, anxiety, and depression in that period of time.

A. I don't remember.

Q. Okay. Now, outside of prison, before you came to prison, did you ever have any instances of feeling like you had loads of energy?

A. Oh, yeah.

Q. Yeah?

A. Uh-huh.

Q. Tell me about that.

A. I'm always a happy person. I always have loads of energy. Like, I'm -- I'm never -- I'm not a sad person. I'm not a -- I'm a very happy spirit person.

Q. Did you have any experiences with transphobia

before coming to prison?

A. No.

Q. No?

A. Definitely not.

Q. When you would, I don't know, go out to the grocery store, you never encountered what you felt like was people being transphobic or anything like that?

A. Like people being transphobic towards me, or me being transphobic towards people?

Q. No, no, no, no. People being transphobic towards you?

A. I mean, yeah. That's just everyday life.

Q. Right.

A. I mean, but if it was, I didn't know anything about it. Nobody has never approached me about it. Like, nobody has ever say, hey, this, this, and that. I lived a very -- my life prior to prison was -- I lived as being almost like a staff transgender woman. Like, I didn't -- I didn't use the label as transgender. I used woman with everything that I did.

Q. Okay. And so you -- did you encounter -- you didn't encounter much misgendering then?

A. No.

Q. Okay.

A. I don't think that's a -- if it -- I didn't

-- if it happens in the world to people, I mean, it's probably, as people will call it, clockable people. I just don't feel I live my life as a clockable trans person.

Q. So, then, in your daily sort of life before prison, you don't recall having many episodes where, you know, you came home from a social interaction and feeling kind of down on yourself because of that interaction, feeling like maybe that person was transphobic or misgendered you or anything like that?

A. No.

Q. Before you came to prison in October of 2017, had you ever tried to harm yourself?

A. I had multiple incidents of not, like, suicidal, but like trying to harm myself from when I was younger [redacted] where I had thoughts of just being harm -- like harming myself. But I only have one incidence where I wanted to commit suicide.

Q. So -- so when you were younger, you -- you said you tried to harm yourself?

A. Yes.

Q. Can you tell me a little bit about that? Was it cutting?

A. No. I ran in front of a car.

Q. You ran in front of a car?

A. Yes.

Q. How old were you?

A. Maybe 13, 14.

Q. Was that the -- the suicide attempt you were talking about?

A. Yes.

Q. Any other history of self-harm?

A. No.

Q. What about ideation, thinking about harming yourself before -- before prison?

A. Oh, no.

Q. Are you aware of any family history of suicide attempts?

A. My mother.

Q. She tried to kill herself?

A. Once she found out she had breast cancer, she tried to jump off a bridge.

Q. Did she actually jump?

A. I think they prevented her from jumping.

Q. Okay. So since coming to prison in October of 2017, have you had any difficulty sleeping?

A. Not sleeping.

Q. Now, describe to me -- I'm going to have to break this up so it's maybe easier for me. Describe

what types of things cause you distress in prison. Not specific to your gender. You can include your gender dysphoria, but give me some examples of things that cause you distress in prison.

A. Misgendering -- misgendering me, using incorrect pronouns, people just not getting trans people and the care that it needs. And not being able to be as sociably accepted as, like, the next female is more socially effected. Like, that's a big deal.

Q. Okay. All -- all of those things sound like they're related to your gender dysphoria.

A. Those are my only issues in prison.

Q. Okay. You don't have any other -- nothing else about being in prison causes you distress?

A. No. I do what I'm supposed to do. I go to school, take classes. I work. I just -- no. It's just everything has something surrounding around my dysphoria or me identifying as trans.

Q. Other aspects of the incarcerated environment don't cause you distress?

A. I mean, it's stressful to be in prison, but no.

Q. What about anxiety? What sort of things cause you anxiety in prison?

A. Things that can cause me anxiety in prison is

to just when people just don't get it. Like, that's, like, the biggest thing is just people not understanding.

Q. And "people," are you referring to -- who are you referring to when you say "people"?

A. Staff, doctors, lawyers, inmates, everybody.

Q. And that causes you anxiety --

A. Yes.

Q. -- when they don't get it?

Now, on a scale of 0 to 100 or 0 to 10, how would you rate the level of distress that you feel around those various issues that you discussed?

A. I would say two years ago it was higher, maybe 20. Now I will say 5.

Q. Out of 100?

A. Yes.

Q. So two years ago meaning before you came to Anson?

A. No. I've been in Anson almost four years.

Q. Oh, yeah. My mistake. So what happened two years ago?

A. Two years ago -- like, for the first two years in Anson, things was just -- I think people was trying to acclimate with me. I was trying to acclimate with them. They was trying to understand, trying to

get it, trying not to get it. I don't know. It was just a -- a very crazy world two years ago.

From '19 till the end of '20, it was just a very -- from August 2019 to December 2020, it was a very weird time here. But after that, it's just -- it's been -- I guess people understand, you know, I'm here now.

Q. Right. So like a little -- some adjusting --

A. A lot of adjustment had to happen, yes.

Q. And after that adjustment and those growing pains, you feel like your level of distress has improved significantly?

A. Anxiety has.

Q. Anxiety. Excuse me. Anxiety.

A. Yes.

Q. Okay. So that was the anxiety that you rated at 20 a couple years back and then now down to 5?

A. Yes.

Q. What about your level of distress?

A. I feel like my distress level stays the same because my distress is just totally focused on my dysphoria.

Q. Okay. And where would you rate that?

A. Off the charts, but, like, really high, like 75, 80 probably or higher.

Q. And would you say that that's been consistent your entire incarceration?

A. It -- I would say at the beginning, it was 75, 80. When I thought I had some kind of understanding mid-2021, it kind of went down a little bit. And now with this current situation with my dysphoria litigation, everything is back to the roof again.

Q. And -- and what is it in particular that you think, if you can pinpoint, is causing this dysphoria -- causing the distress to be that high?

A. DPS not getting it. They don't -- they're just -- they're just not willing to understand.

Q. Does it have -- how much of that is tied up with the decision on the vulvoplasty?

A. One -- 96 percent of it.

Q. Ninety-six percent. So, in your mind, if the -- your belief is that the -- the vulvoplasty would -- what would your level of distress be after that in prison?

A. Minus the trying to get adequate mental health care, probably back -- probably just normal with everyday distress with life, maybe 5.

Q. What happens in prison if you receive a vulvoplasty, and you are still -- your distress level's

still at a 50?

MS. MAFFETORE: Object to the form. Calls for speculation.

BY MR. RODRIGUEZ:

Q. You can answer.

A. I don't know what -- I can't predict the future.

Q. When -- what about your -- I know you described yourself as a happy person, but do you sometimes get sad?

A. I get sad, but not often. Like, maybe -- it all depends on what's going on. Like being in prison makes you, like, sad because you can't be around your family, but being sad when it comes around to the things that I have going on with my life, I get sad.

But I get more emotionally, like, torn -- like, it's -- it's more emotionally than just, oh, I just feel sad today. It's just more like -- it's -- it's a lot of anguish in my mind like how I feel. It makes me feel like I just -- I don't know. I can't even explain it. I don't know how to put words to it.

Q. And how -- how about the distress? If the distress is -- is running high, how does that affect you day-to-day?

A. I don't allow it to affect my day-to-day.

Those I just try to use tactics that make me feel better.

Q. Like what?

A. Meditation, journaling, calling people on the phone.

Q. Do those things help?

A. Somewhat, yes.

Q. Okay. So after coming to prison, you -- you mentioned before when you were on the outside that you didn't encounter much transphobia; right? Tell me about your encountering transphobia inside of prison, specifically in the men's prisons first before you came to Anson.

A. Men prison was bad because they -- they target you. They make you feel like you're like prey and food or, like, it makes you feel vulnerable.

Q. The other inmates?

A. Yeah. They are -- they are not a great crowd to be around, yeah.

Q. What about the staff?

A. The staff is just as worse. They -- because they are -- are -- and part of it I get because they do work in a men's prison, so in their mind is that everybody here is a guy. But the misgendering and the incorrect pronouns and not giving the undergarments and

not understanding that you need hormones and not understanding that you need this and that is -- it wasn't a great two years.

Q. Yeah. And -- and how did those episodes, those types of scenarios, the misgendering, the pronoun usage, how did those affect you day-to-day?

A. I had a very rough time at the men's prison.

Q. Did you feel that those types of encounters in the men's prison increased your level of distress?

A. It very much. It increased it a lot.

Q. So if you were running at a 70, what would you say -- what kind of a bump would you say you had on the level of distress from being in a men's prison if you were misgendered in the cafeteria or something?

A. I cried almost daily at the men's prison; so I was hurt a lot.

Q. Were you ever physically or sexually assaulted by any -- any inmates at the men's prisons?

A. No, I wasn't.

Q. What about any staff members?

A. I wasn't assaulted by a staff member, but a staff member had to resign because they felt like that he was doing too much for me or something.

Q. Okay. Undue influence or something? One of those phrases.

A. I guess. They gave me work paper and all this other stuff.

Q. No physical?

A. No.

Q. Did you feel that you were ever subject to any retaliation by staff at the men's prisons?

A. Very much so.

Q. Describe some of that for me.

A. I felt like I was retaliated against with the undergarments, and it led to me getting infractions, but they did it within policy. And I feel like all of my -- I feel like all of my retaliation was done within policy. Like it was done blatantly, but it was done -- but they found reason within policy to punish me for it.

And when I attempted to try to wear female garments, I was retaliating about it -- I mean, got -- and got punished for it. Every time I would ask for things at medical, I would get kicked out of medical. And I feel like they retaliated against it.

I feel like when I got the media involved, things got worse as well. And I feel like when ACLU got involved at the men's prison, things kind of got worse again. I was placed in protective custody. Then out of protective custody, I got sent out to a

different men's prison.

Q. Now, how about the move to -- to Anson, to the women's prison, has -- did you encounter any transphobia?

A. At the beginning, yes.

Q. At the beginning?

A. Yes.

Q. What kind of scenarios?

A. The misgendering, the incorrect pronouns, and Miss Warden Richardson basically, I guess, put her foot down, and it kind of died off a little bit. And they went through some kind of cross-gender training or whatever, and things started to get better.

Q. Okay. What about from the female offenders?

A. Oh, yeah, they was really on it. They had articles and everything from printed off the internet and all kinds of stuff about me.

Q. In a good or a bad way?

A. In a bad way.

Q. In a bad way?

A. Yep.

Q. And that was more toward the beginning of your --

A. Yes.

Q. Did you ever feel -- was there ever a period

of time where you felt like you -- perhaps being in a women's facility was -- was more triggering?

A. Yes, I did.

Q. Describe some of that.

A. I felt like it was more triggering because if the women -- women are more hands on, women are more emotional creatures, women are more family-oriented than men are. They are more, you know, who in the shower, let's take a shower. Like, they take showers. You know, it's just things are a little bit more hands on, more family orientated [sic] compared to the men's prison.

It's kind of like you stay in your lane, that's your only lane, nobody else get in your lane. And I couldn't -- and I still to this day, I can't really align with the -- some of the things that they do because I do have that fear that they will see my bottom half of my body.

Q. Do some of your peers here know you still have a phallus?

A. They do because of articles, newspaper articles.

Q. Okay. Since -- since coming to prison in 2017, tell me a little bit about your -- your suicidal ideation or self-harm attempts.

A. The first one was in March of 2019. I took an overdose of medication. Then after those times, on numerous occasions, I told Dr. Hahn that I was going to mutilate my phallus. Phallus, phallus, however you -- you say it different ways.

And then in I want to say it was either March or April, but the beginning of 2011, I tied a band around my phallus area. Dr. Hahn had to get it removed.

In December of 2020, after I got into a situation in here in Anson, I told Dr. Hahn that I just feel -- I'd rather feel like I wasn't alive, and that I was going to pull the skin off myself. And those are the ones I remember.

Q. What kind of pills did you try to overdose with?

A. Chloraphine [sic].

Q. What's -- what's that prescribed for?

A. It's allergy medications.

Q. Was it your prescription?

A. No, they sell them in the commissary.

Q. They sell them at the commissary?

A. Yes.

Q. Since your incarceration, have you had any -- particularly at the beginning of your incarceration,

everybody.

Q. You mentioned earlier that you probably would need therapy for the rest of your life for, not just gender dysphoria issues, but other trauma you suffered in the past. Is that -- is that a fair statement?

A. That's part of it.

Q. Have you since being incarcerated had any distress or anxiety and depression sort of tied up in those issues, the trauma from your past?

A. No.

Q. No? Have you ever had any difficult conversations with one of your mental health providers that maybe dredged up some stuff?

A. They never even talked about it.

Q. So you've never had -- been able to go into your past?

A. I have told them that I had these issues, but the dysphoria issues has always stayed on the front burner. They have never gotten to the chance to get to the back burner.

Q. What about -- describe your feelings about the mental health staff that you've had access to here.

A. Dr. Hahn has been the only knowledgeable -- and I get very emotional when I talk about her, because she was the only person who got me. She understood,

and I feel that DPS took her away from me. And that's all I kind of want to say about it.

Q. She retired; correct?

A. I feel like they forced her to retire.

MS. MAFFETORE: Do you want a second?

THE WITNESS: No, I'm going to be okay.

BY MR. RODRIGUEZ:

Q. So aside from Dr. Hahn, you haven't been impressed with the staff that they have here, mental health staff?

A. Dr. Hahn was with me from the time that Ms. Garvey made her recommendations for everything for me in October of 2017 until she retired in July of 2021. And Dr. Hahn, when I had her, things was happening for me and things was going in the right direction.

And I feel like when it got to home base where things suppose to happen, they was drafted away. And that's just my personal belief. Nobody has told me that. It's just conversations that me and her had, that it's just totally how can that have happened, and now this is happening. It just -- it just makes me feel that way.

Q. Have you -- I'm sorry.

A. Just go ahead.

anymore. It's like a forest. Like we -- people just, geographically, they just don't understand, and they just don't get it.

Q. So you would prefer to be at NCCIW?

A. Yes.

Q. I want to talk about the March 2nd, 2019, incident. Can you tell me -- tell me what happened and caused you to end up at the emergency room that day.

A. Okay. So Dr. Hahn had came and seen me like a few days prior to that, and she told me that Mr. Junker was going to move me to a women's prison. And on March the 1st, I come to find out that they say they was not going to move me from a women's -- to a men's prison. That they was going to move me to Warren Correctional Center.

And I asked them why. And they was basically telling me, DTARC just didn't recommend it. They were still looking at more things like visiting other states, and they was just looking at more experiences, more literature, whatever.

So I was like, okay. Well, I went back to the dorm, and I just felt like that -- I just didn't -- I wanted to give up. So I just went to the commissary. I had other people to buy me -- I don't even remember the number of chloraphines that I bought. Got on my

bed, and I guess when it affected, I remember going up and down, up and down, and I kept yelling for my grandmother.

And then, you know, the captain came. I vomited on his foot. They took me to medical. They said I said some threatening things to the medical staff, and then I went to the hospital. When I got there, they was trying to treat me for -- I don't know what it was, like anxiety or -- or panic attack or whatnot. So they gave me some kind of injection in my leg, and I was like, Like, what is this for?

And the staff was telling me to the whole time, well, they believe that you had did K2. And I was like, I haven't done any type of drug. So, you know, they gave me the urinalysis and whatnot. They brought me back to the prison, and they locked me in seg.

Q. Segregation?

A. Yeah.

Q. What time of day did -- did you end up going out to the emergency room?

A. At nighttime. Maybe 8:00 or 9:00 at night, I think.

Q. Okay. Did you ever report to anyone that you had tried to overdose on allergy medicine?

A. Oh, yeah, the nurse and everybody. But they said that I told the captain or somebody that I smoked something out of a pipe.

Q. So you recall telling the nurse that day that you had tried to overdose on allergy medication?

A. This was the nurses at the hospital.

Q. At the hospital?

A. Uh-huh. They had carried me to Harnett Hospital or Harnett Correctional Hospital -- I mean, Harnett Regional or something like that.

Q. What about the medical staff at the facility, did you tell them that --

A. I never spoke to them. They put me on --

Q. You never talked to any of the medical providers? Any nurses?

A. No.

Q. Okay.

A. Not that I remember anyway. I don't remember. All I remember is going from the dorm -- they put me in a wheelchair. I went to medical. They put some shoes on me, and they put me in the back of the EMS, and I was at the hospital.

Q. But you remember telling the nurses at the hospital that you had taken allergy medicine or --

A. Uh-huh.

Q. -- or tried to overdose on allergy medicine?

A. Yeah, she was like, what was wrong? And I told her I didn't want to be at the men's prison anymore. Like, she -- I went in details and tell her why I did it. She asked me why. Like, this is after they had gave me some kind of injection in my leg.

Q. Okay. Did you mention being high to anybody?

A. I didn't tell anybody. But when I got my incident report, they told me that I told them that I smoked something out of a pipe, that I had called the head nurse Ms. Tammy Black all kinds of bad names, and that I had assaulted the captain.

Q. And did you say anything about smoking anything out of a pipe?

A. No, I would never admit to something I know I didn't do.

Q. Have you ever taken any illicit substances since being incarcerated?

A. No, I have not.

Q. Did you take a blood test when you were at the hospital?

A. Nope.

Q. Did you refuse a blood test when you were at the hospital?

A. That's what they said. They said I refused a

blood test by saying that I wanted to go back to the prison. I told them I wanted to go back to the prison. They released me and sent me back. And they said in the midst of that day that I refused to test. But they gave me a urinalysis at the -- at the prison, though, when I got back.

Q. Do you -- did you think you were having a panic episode?

A. I was having a panic attack.

Q. What about seizures? Do you think you were having a seizure?

A. I do have a history of them; so I don't know if I was -- I don't know if --

(Clarification by the reporter.)

THE WITNESS: Yeah, I do have a history of seizures, but I don't know if I was having one that day.

BY MR. RODRIGUEZ:

Q. Have you been diagnosed with any kind of seizures disorder?

A. Yes, it's on my -- in my medical records as well.

Q. Have you been hospitalized ever for a seizure?

A. No.

Q. Do you remember speaking with a Ms. Laub or Laub?

A. Uh-huh. That's one -- that's the one I talked to on that March the 2nd, that day after Dr. Hahn had left. That's the one who told me that I was getting transferred to Warren.

Q. So this was -- you -- you attempted to kill yourself that day on March 2nd?

A. That was -- yes, that night.

Q. Okay. Tell me about the April 26th, 2019, incident. You were sent out to the emergency room again.

A. That was at Warren Correctional. And I was in my room and just blanked out. I kept hollering and screaming. They said that my blood pressure went down, so they sent me to the emergency room. And the doctor said it was a panic attack.

Q. Do you remember being upset earlier that day?

A. Yes.

Q. What -- what about?

A. I think Dr. Hahn had came and seen me like that day or like a day before or something like that and was telling me that Mr. Junker had said something about that I won't be moved for like 90 days or something like that. It was some kind of news that she

had told me that DTARC had said. It was something crazy or something they said. Something that I probably didn't want to hear.

Q. Did you have a -- so you had a therapy session with Dr. Hahn sometime around prior to being -- having this episode?

A. Yes.

Q. During that therapy session, were there discussions that you had with Dr. Hahn that upset you about your past?

A. Yes. It was something she had told me that I don't remember exactly what she told me.

Q. So what do you feel like your episode of distress in that instance was caused by?

A. I think it was something -- if I remember correctly, it was something about them not going to move me right then. That I wasn't going to be moved or -- they had -- DTARC had denied something.

Q. And during this episode, did you have any suicidal ideations?

A. I don't think I told them -- no, I didn't -- no, I never told anyone that I remember that I wanted to die that day. When I came back from the hospital, they told me I was going to seg, and I told them that I didn't want to go there. I didn't want to be in seg.

They placed me on suicidal watch. And the warden had to come get me out the next day.

Q. Was that in April?

A. Yeah.

Q. Okay. Tell me about August 6th, 2019, when you went out to the emergency room again. What led up to that episode?

A. I don't -- I don't remember that one. August. At least I'm getting the two mixed up from April to August.

Q. Were you -- do you remember being stressed out about the -- when did you transfer to Anson?

A. April 15th. I mean, August 15th.

Q. Okay. So August 6th, 2019, do you recall being perhaps nervous or upset about the upcoming transfer to the female facility? Maybe anxious, nervous?

A. I think I -- I think I talked to the psychiatrist, but I don't remember going to the hospital. I don't know if I went to the hospital in April or August, but I remember going to the hospital once when I was there.

Q. Now, when you -- so for purposes of this question, assume you went out to the emergency room on August 6th, 2019, came back to, I guess, Harnett --

yeah, Harnett. You were informed that you were going to be put in segregation.

A. That was in March that I was at Harnett, and I got put in segregation when I came back. As a matter of fact, April, I didn't go to the hospital in April. April, I just had -- I think I had an incident in mental health. And I was telling me I was going through it, and I think I went to the hospital in August, and they put me in seg. Because I didn't go to seg in April. They put me on suicide watch in August, I think it was.

Q. Right. Okay. So in August, upon your return from the emergency room, they placed you in segregation?

A. They put me on suicide watch.

Q. Now, before -- before you returned to the -- to the facility, did you have any -- did you make any comments related to wanting to harm yourself?

A. Yeah, I -- once I -- when I was in medical, I think I did. I told the man when I got back, I think I told -- I think I told him, because that's why they put me on suicide watch.

Q. And then the next day you were removed from suicide watch; right?

A. Yes.

Q. Do you recall that conversation with the warden?

A. Uh-huh. She came down there, and she said -- ask me how I was feeling. She said she saw that I passed my urinalysis test. That, you know, no matter what they was saying, if I was, if I wasn't doing any illicit drugs, that I don't need to be doing it. That she was putting me back in population. And that, you know, my transfer was going to come up soon.

And she didn't -- after that, she used to come check on me like every few -- every three or four days until I left.

Q. Do you remember talking about your history of suicide attempts with the warden at that time?

A. I think I did.

Q. What would you have said?

A. I don't remember.

Q. But this was after you had the March episode; right?

A. Yes.

Q. What happened in September 2020 with the -- the A21 disciplinary offense for strong arming and extortion?

A. I was working in the commissary, and the sergeant wrote me up for overcharging someone for a

turkey and cheese hoagie.

Q. And you -- you were disciplined for that?

A. I got found guilty for it. I pleaded not guilty, and they found me guilty based off a confidential informant.

Q. How did that episode impact your relationship with the other offenders in Anson?

A. Nobody believed it. I was their commissary worker for like a year. I was -- I became their commissary worker like a week after I got here all the way up until like September of that year. And -- and there was never an issue. It was just simply, once again, I think people -- the sergeant.

Because it was a sergeant who did it, trying to acclimate himself with it now. Because now he's my unit sergeant, and there's no issue. So I still don't know how I got found guilty off that one.

Q. And then what about the December 7th, 2020, incident? Tell me about that A10 fighting charge?

A. They charged me with fight with a weapon, but I don't know how I got charged with it because there was never a weapon involved. But they said I got charged with that because it was a mutual fight outside. Medical say there was a two-part write-up. I have no idea how that happened.

But they -- I got in a fight because the offender was saying some very ugly things, and she had a piece of paper that was printed off from her lawyer that she do podcast with about some -- about my phallus, and how I was getting ready to try to take litigation with DPS, about a news articles I had done with these people.

And she was like, what are you going to do? Pipe me down with your penis? And we went upstairs -- I went upstairs. I went to her dorm. I said, Can you please apologize to me? And she didn't apologize. She hit me twice. And then she took my glasses off, balled them up, and then I fought back for myself, and I went to seg.

Like, that was a Monday. And then that Friday they lock her up after they viewed the camera and saw that she had initiated the fight.

Q. So you were in segregation, then, I assume shortly after the incident, the altercation?

A. Uh-huh.

Q. And then, this was around the time that you went to NCCIW; right?

A. Yeah, I went, like, inside there a week later.

Q. And were you still in segregation when you

went to NCCIW?

A. Yes.

Q. Were you upset by being in segregation because of the altercation?

A. It initiated because I was upset that I fought somebody.

Q. So why did you -- why did you end up going to NCCIW?

A. Dr. Hahn felt that it was best for me to be in a different environment after expressing to her that I didn't want to live anymore and that I wanted to pull the skin off myself. And being that they had brought the other girl in to that same segregation area, they deemed it would be better for me to be at NCCIW. So she called and had me placed in their inpatient there while I was doing my segregation time.

Q. So was the -- was the move to NCCIW during that period of time precipitated because of your -- your reaction, your emotional reaction to the -- to the discipline, the fight and the disciplinary charges?

A. I think it was done based off of me telling her I wanted to harm myself.

Q. And that -- that happened shortly after the incident with the other offender; right?

A. That happened five days later.

Q. While you were still in segregation?

A. Yes.

Q. After you -- after you got to NCCIW inpatient, what was your mood like?

A. Well, the first day, I was kind of -- didn't feel so well. Like, I was -- I was kind of not in great spirits. The second day the psychiatrist -- the psychiatrist came and spoke to me, did an assessment on me. And I think like the third day the treatment team came by asking me did I feel hopeless. And I was, like, No, I don't feel hopeless.

And she was, like, okay. I'm going to take you off of acute, and I'm going to move you to chronic. They put me in chronic care, and I stayed in chronic care. And I just told them I didn't want to -- I did not want to be back at Anson. That I preferred to stay there. And they told me if I didn't go back to Anson, that they was going to initiate that I go back to the men's prison. And I said, Okay.

Then I got placed on Zoloft. Then they moved to a different segregation unit. Then when they told me I was getting ready to transfer back to Anson, I told them I did not want to go to Anson, and if they moved me to Anson, I was going to kill myself. So they kept me for an extra day.

Then, the second day the therapist came and saw me, and Dr. Mann had made the decision that I was not suicidal, and they transferred me on a Code Red during COVID back to Anson.

Q. So I want to -- I want to drill down a little bit on the -- the report to Dr. Hahn about wanting to rip the skin off of your phallus.

Were you upset when you made that comment to Dr. Hahn about the altercation you had with the offender and what she said to you?

A. I was upset at myself for allowing someone to get to me like that. And my thing was that this phallus is causing me all kinds of distress. It's messing with me emotionally. I just rip it off, I take it off, it'll get me to the doctor so it would have to be gone. That was my whole intention.

Q. But -- but for the interaction with the offender, do you believe you would have made that kind of a comment to Dr. Hahn?

A. I had been making those comments to Dr. Hahn for a long time.

Q. Before --

A. Yes.

Q. Before this?

A. Yes.

Q. You mentioned earlier that Dr. Hahn had to get the band removed. This was an episode where you put a rubber band around your phallus?

A. Yes.

Q. How many times did you do that?

A. I have done it numerous but -- times, but the time where staff actually knew and had to assist me to get it off was once. Times I told them I was going to do it and actually done it, and I took it off myself at a later time, I would say three or four.

Q. So you've -- so you've put a band around your phallus three or four times where nobody else knew about it?

A. Right.

Q. And only once where someone else knew about it?

A. Right.

Q. And you -- did you need assistance to remove the band?

A. She just made sure it was there. She went to the restroom with me to make sure that I took it off. But I took it off myself.

Q. She went with you to the restroom?

A. Yeah, she was outside the door.

Q. Okay. She wasn't inside the restroom with

you?

A. No, no. It was a staff member, a nurse -- a staff meaning officer, a nurse, and her.

Q. What did you do with the rubber band?

A. They took it, and I think they threw it away. They put it in a red bag and threw it away.

Q. And the -- the three to four incidences where no one knew, when were those incidents in relation to the one with Dr. Hahn?

A. Either prior or after. Like instance where -- like, in one instance, like, maybe a nurse have told me or nurse practitioner have told me that I wasn't going to get the care, DTARC had denied me, and I act out my emotions. And I went to my room and just felt like it was just better if I just take it off myself since nobody else didn't want to do it.

Q. When would have been the most recent time that this happened?

A. The last time was with Dr. Hahn.

Q. The last time was with Dr. Hahn?

A. Yeah.

Q. So the most recent one was the one with Dr. Hahn, and that was before the NCCIW inpatient?

A. Yes.

Q. Okay. So pre-December 2020?

A. Yes.

Q. So since December 2020, have you attempted to -- have you put a rubber band on your phallus?

A. No.

Q. Have you made any other attempts at self-harm?

A. No.

Q. All right. I think this is a good stopping point for another short break, and then -- then we'll be pretty close, I think.

THE VIDEOGRAPHER: The time on the monitor is 2:30 p.m. We are off the record.

(Whereupon a short recess was taken.)

THE VIDEOGRAPHER: The time on the monitor is 2:43 p.m. We are back on the record.

MS. MAFFETORE: Before you resume your questioning, I believe on break we realized that Kanautica needed to clarify the timeline regarding the incident that you were just discussing before the break.

MR. RODRIGUEZ: All right.

MS. MAFFETORE: So did you want to clarify?

THE WITNESS: Yeah. The last time I spoke with Dr. Hahn was April of 2021. That was about the phallus area when they took the band off.

BY MR. RODRIGUEZ:

Q. Okay. So April 2021 was --

A. Yeah.

Q. -- the band that -- that Hahn knew about?

A. Yeah.

Q. And so the three to four incidents where she didn't know or nobody knew about it, that was beforehand?

A. Yeah, that was prior to then.

Q. Okay.

A. Yep.

Q. So since April 2021, any other episodes?

A. No.

Q. No other attempts to -- to harm yourself?

A. No.

Q. Thank you for clarifying that.

Okay. Let's see. I understand you have been in communication with various -- and you mentioned some of this earlier, like various advocacy groups?

A. Uh-huh.

Q. Can you tell me some about that? Aside from, obviously, the ACLU, who else have you been in communication with?

A. BYP100, Southerners Underground, The House of Kanautica, Gender Benders, Trans Mission, Equality ENC.

not so right at the prison or not going right within DPS.

Q. Do you engage in advocacy efforts for people other than yourself?

A. No.

Q. Do you feel any -- any pressure related to your involvement with these organizations?

A. Like, can you rephrase it?

Q. Does it cause you any kind of stress or pressure dealing with communicating with these organizations?

A. No.

Q. Do you have any general suggestions as to how perhaps life of transgender incarcerated people can be improved?

A. Yes, I have a lot of suggestions for that. I would suggest that there be a better gender training with understanding LGBTQ individuals. Understanding trans people -- incarcerated trans people, emphasis on incarcerated. The understanding of people pronouns and their gender identification. Therapy surrounding trans care or gender-affirming care or any type of care around LGBTQ rights and organization advocacy, classes. I would say that's about it.

Q. What's been your motivation? Why have you

reached out to the media at various times during your incarceration?

A. It started out with DPS kept telling me things that wasn't true.

Q. And has the media attention, has that been a source of stress for you?

A. I'm not going to say it's a source of stress. Here -- maybe like in the last year or so, having to put myself back in the media has made things a little bit kind of -- maybe a little stressful.

Q. Have you felt compelled to do that?

A. I felt that was my only way to advocate for myself.

Q. What about your -- your current release date? What's your understanding of where that stands?

A. November 2nd, 2024.

Q. And what's your custody level?

A. Medium.

Q. Have you had a custody review recently?

A. I did have one in December, but it was denied because I had those three infractions from the men's prison. I have been told that I should have another custody review on February the 3rd.

Q. Have you had any clarity about the infractions? Are they going to be adjusted at all?

A. No. They said that they're there, and they have to stay there until the end of 2000 -- of this year, 2023. That the male infractions at the male prison classifies different from the ones that the -- that the females' facility classifies.

Like my infraction I got here is already gone from my record, but I'm still holding the ones at the male prison because they stay on their record for five years, but female stay on for a year.

Q. So when you're -- when you're released, what are your plans?

A. I plan to find employment as a paralegal. Try my best to, like, really lobby for myself to get into law school. Be back with my husband so we can try to make up some lost times. Be with my family. And -- and it's just kind of, like, sad to say, but if, you know, DPS doesn't give me my surgery, definitely have my surgery.

Q. That was going to be my next question. If you were denied the surgery, you would pursue it after you were released?

A. Yes.

Q. Where does your husband live now?

A. He stays in Raleigh, North Carolina.

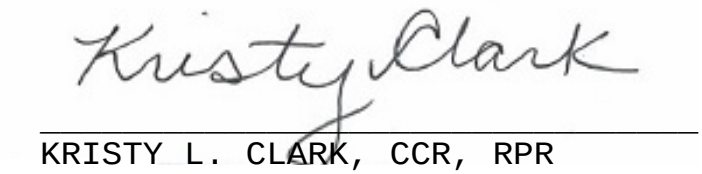
Q. He lives in Raleigh?

STATE OF NORTH CAROLINA)
) C E R T I F I C A T E
COUNTY OF MECKLENBURG)

I, Kristy Clark, Notary Public, do hereby certify that KANAUTICA ZAYRE-BROWN was duly sworn by me prior to the taking of her deposition; that said deposition was taken and transcribed by me; and that the foregoing pages are a true and accurate transcript of the testimony of said witness. I further certify that the persons were present as stated.

I further certify I am not of counsel for or in the employment of any of the parties to this action, nor am I interested in the result of said action.

IN WITNESS WHEREOF, I have hereunto subscribed my name, this 1st day of February, 2023.



KRISTY L. CLARK, CCR, RPR
Notary #201807900150
My Commission Expires: 3/20/2023

VERIFICATION OF DEPONENT

I, KANAUTICA ZAYRE-BROWN, have read the foregoing deposition testimony, which was reported by Kristy Clark, RPR and Notary Public in and for the State of North Carolina, on January 18, 2023.

I find the transcript of my testimony to be true and accurate according to my testimony on that date, with the exception of _____ corrections as listed on the attached errata page, which was completed by me.

_____
KANAUTICA ZAYRE-BROWN

_____, 2023.

Sworn and subscribed to before me
this ____ day of _____, 2023.

_____
Notary Public

My commission expires:_____

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1 This is the seventh version of the Standards of Care. The original SOC were published in 1979. Previous revisions were in 1980, 1981, 1990, 1998, and 2001.

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Purpose and Use of the Standards of Care

The World Professional Association for Transgender Health (WPATH)[1] is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health. The vision of WPATH is to bring together diverse professionals dedicated to developing best practices and supportive policies worldwide that promote health, research, education, respect, dignity, and equality for transsexual, transgender, and gender nonconforming people in all cultural settings.

One of the main functions of WPATH is to promote the highest standards of health care for individuals through the articulation of *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People*. The *SOC* are based on the best available science and expert professional consensus.[2] Most of the research and experience in this field comes from a North American and Western European perspective; thus, adaptations of the *SOC* to other parts of the world are necessary. Suggestions for ways of thinking about cultural relativity and cultural competence are included in this version of the *SOC*.

The overall goal of the *SOC* is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments. While this is primarily a document for health professionals, the *SOC* may also be used by individuals, their families, and social institutions to understand how they can assist with promoting optimal health for members of this diverse population.

WPATH recognizes that health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and legal reforms that promote tolerance and equity

1 Formerly the Harry Benjamin International Gender Dysphoria Association

2 *Standards of Care (SOC), Version 7* represents a significant departure from previous versions. Changes in this version are based upon significant cultural shifts, advances in clinical knowledge, and appreciation of the many health care issues that can arise for transsexual, transgender, and gender nonconforming people beyond hormone therapy and surgery (Coleman, 2009a, b, c, d).

for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma. WPATH is committed to advocacy for these changes in public policies and legal reforms.

The Standards of Care Are Flexible Clinical Guidelines

The *SOC* are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people. While flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing gender dysphoria – broadly defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

As for all previous versions of the *SOC*, the criteria put forth in this document for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

The *SOC* articulate standards of care but also acknowledge the role of making informed choices and the value of harm reduction approaches. In addition, this version of the *SOC* recognizes and validates various expressions of gender that may not necessitate psychological, hormonal, or surgical treatments. Some patients who present for care will have made significant self-directed progress towards gender role changes, transition, or other resolutions regarding their gender identity or gender dysphoria. Other patients will require more intensive services. Health professionals can use the *SOC* to help patients consider the full range of health services open to them, in accordance with their clinical needs and goals for gender expression.

II

Global Applicability of the Standards of Care

While the *SOC* are intended for worldwide use, WPATH acknowledges that much of the recorded clinical experience and knowledge in this area of health care is derived from North American and Western European sources. From place to place, both across and within nations, there are differences in all of the following: social attitudes towards transsexual, transgender, and gender nonconforming people; constructions of gender roles and identities; language used to describe different gender identities; epidemiology of gender dysphoria; access to and cost of treatment; therapies offered; number and type of professionals who provide care; and legal and policy issues related to this area of health care (Winter, 2009).

It is impossible for the *SOC* to reflect all of these differences. In applying these standards to other cultural contexts, health professionals must be sensitive to these differences and adapt the *SOC* according to local realities. For example, in a number of cultures, gender nonconforming people are found in such numbers and living in such ways as to make them highly socially visible (Peletz, 2006). In settings such as these, it is common for people to initiate a change in their gender expression and physical characteristics while in their teens, or even earlier. Many grow up and live in a social, cultural, and even linguistic context quite unlike that of Western cultures. Yet almost all experience prejudice (Peletz, 2006; Winter, 2009). In many cultures, social stigma towards gender nonconformity is widespread and gender roles are highly prescriptive (Winter et al., 2009). Gender nonconforming people in these settings are forced to be hidden, and therefore may lack opportunities for adequate health care (Winter, 2009).

The *SOC* are not intended to limit efforts to provide the best available care to all individuals. Health professionals throughout the world – even in areas with limited resources and training opportunities – can apply the many core principles that undergird the *SOC*. These principles include the following: Exhibit respect for patients with nonconforming gender identities (do not pathologize differences in gender identity or expression); provide care (or refer to knowledgeable colleagues) that affirms patients' gender identities and reduces the distress of gender dysphoria, when present; become knowledgeable about the health care needs of transsexual, transgender, and gender nonconforming people, including the benefits and risks of treatment options for gender dysphoria; match the treatment approach to the specific needs of patients, particularly their goals for gender expression and need for relief from gender dysphoria; facilitate access to appropriate care; seek patients' informed consent before providing treatment; offer continuity of care; and be prepared to support and advocate for patients within their families and communities (schools, workplaces, and other settings).

Terminology is culturally and time-dependent and is rapidly evolving. It is important to use respectful language in different places and times, and among different people. As the *SOC* are translated into other languages, great care must be taken to ensure that the meanings of terms are accurately translated. Terminology in English may not be easily translated into other languages, and vice versa. Some languages do not have equivalent words to describe the various terms within this document; hence, translators should be cognizant of the underlying goals of treatment and articulate culturally applicable guidance for reaching those goals.

The Difference Between Gender Nonconformity and Gender Dysphoria

Being Transsexual, Transgender, or Gender Nonconforming Is a Matter of Diversity, Not Pathology

WPATH released a statement in May 2010 urging the de-psychopathologization of gender nonconformity worldwide (WPATH Board of Directors, 2010). This statement noted that "the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative."

Unfortunately, there is stigma attached to gender nonconformity in many societies around the world. Such stigma can lead to prejudice and discrimination, resulting in "minority stress" (I. H. Meyer, 2003). Minority stress is unique (additive to general stressors experienced by all people), socially based, and chronic, and may make transsexual, transgender, and gender nonconforming individuals more vulnerable to developing mental health concerns such as anxiety and depression (Institute of Medicine, 2011). In addition to prejudice and discrimination in society at large, stigma can contribute to abuse and neglect in one's relationships with peers and family members, which in turn can lead to psychological distress. However, these symptoms are socially induced and are not inherent to being transsexual, transgender, or gender nonconforming.

Gender Nonconformity Is Not the Same as Gender Dysphoria

Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (Institute of Medicine, 2011). *Gender dysphoria* refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b). Only *some* gender nonconforming people experience gender dysphoria at *some* point in their lives.

Treatment is available to assist people with such distress to explore their gender identity and find a gender role that is comfortable for them (Bockting & Goldberg, 2006). Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person. This process may or may not involve a change in gender expression or body modifications. Medical treatment options include, for example, feminization or masculinization of the body through hormone therapy and/or surgery, which are effective in alleviating gender dysphoria and are medically necessary for many people. Gender identities and expressions are diverse, and hormones and surgery are just two of many options available to assist people with achieving comfort with self and identity.

Gender dysphoria can in large part be alleviated through treatment (Murad et al., 2010). Hence, while transsexual, transgender, and gender nonconforming people may experience gender dysphoria at some point in their lives, many individuals who receive treatment will find a gender role and expression that is comfortable for them, even if these differ from those associated with their sex assigned at birth, or from prevailing gender norms and expectations.

Diagnoses Related to Gender Dysphoria

Some people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder. Such a diagnosis is not a license for stigmatization or for the deprivation of civil and human rights. Existing classification systems such as the *Diagnostic Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association, 2000) and the *International Classification of Diseases* (*ICD*) (World Health Organization, 2007) define hundreds of mental disorders that vary in onset, duration, pathogenesis, functional disability, and treatability. All of these systems attempt to classify clusters of symptoms and conditions, not the individuals themselves. A disorder is a description of something with which a person might struggle, not a description of the person or the person's identity.

Thus, transsexual, transgender, and gender nonconforming individuals are not inherently disordered. Rather, the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available. The existence of a diagnosis for such dysphoria often facilitates access to health care and can guide further research into effective treatments.

Research is leading to new diagnostic nomenclatures, and terms are changing in both the *DSM* (Cohen-Kettenis & Pfäfflin, 2010; Knudson, De Cuypere, & Bockting, 2010b; Meyer-Bahlburg, 2010; Zucker, 2010) and the *ICD*. For this reason, familiar terms are employed in the *SOC* and definitions are provided for terms that may be emerging. Health professionals should refer to the most current diagnostic criteria and appropriate codes to apply in their practice areas.

IV
Epidemiologic Considerations

Formal epidemiologic studies on the incidence[3] and prevalence[4] of transsexualism specifically or transgender and gender nonconforming identities in general have not been conducted, and efforts to achieve realistic estimates are fraught with enormous difficulties (Institute of Medicine, 2011; Zucker & Lawrence, 2009). Even if epidemiologic studies established that a similar proportion of transsexual, transgender, or gender nonconforming people existed all over the world, it is likely that cultural differences from one country to another would alter both the behavioral expressions of different gender identities and the extent to which gender dysphoria – distinct from one's gender identity – is actually occurring in a population. While in most countries, crossing normative gender boundaries generates moral censure rather than compassion, there are examples in certain cultures of gender nonconforming behaviors (e.g., in spiritual leaders) that are less stigmatized and even revered (Besnier, 1994; Bolin, 1988; Chiñas, 1995; Coleman, Colgan, & Gooren, 1992; Costa & Matzner, 2007; Jackson & Sullivan, 1999; Nanda, 1998; Taywaditep, Coleman, & Dumronggittigule, 1997).

For various reasons, researchers who have studied incidence and prevalence have tended to focus on the most easily counted subgroup of gender nonconforming individuals: transsexual individuals who experience gender dysphoria and who present for gender-transition-related care at specialist gender clinics (Zucker & Lawrence, 2009). Most studies have been conducted in European

3 **incidence**—the number of new cases arising in a given period (e.g., a year)
4 **prevalence**—the number of individuals having a condition, divided by the number of people in the general population

countries such as Sweden (Wålinder, 1968, 1971), the United Kingdom (Hoenig & Kenna, 1974), the Netherlands (Bakker, Van Kesteren, Gooren, & Bezemer, 1993; Eklund, Gooren, & Bezemer, 1988; van Kesteren, Gooren, & Megens, 1996), Germany (Weitze & Osburg, 1996), and Belgium (De Cuypere et al., 2007). One was conducted in Singapore (Tsoi, 1988).

De Cuypere and colleagues (2007) reviewed such studies, as well as conducted their own. Together, those studies span 39 years. Leaving aside two outlier findings from Pauly in 1968 and Tsoi in 1988, ten studies involving eight countries remain. The prevalence figures reported in these ten studies range from 1:11,900 to 1:45,000 for male-to-female individuals (MtF) and 1:30,400 to 1:200,000 for female-to-male (FtM) individuals. Some scholars have suggested that the prevalence is much higher, depending on the methodology used in the research (for example, Olyslager & Conway, 2007).

Direct comparisons across studies are impossible, as each differed in their data collection methods and in their criteria for documenting a person as transsexual (e.g., whether or not a person had undergone genital reconstruction, versus had initiated hormone therapy, versus had come to the clinic seeking medically-supervised transition services). The trend appears to be towards higher prevalence rates in the more recent studies, possibly indicating increasing numbers of people seeking clinical care. Support for this interpretation comes from research by Reed and colleagues (2009), who reported a doubling of the numbers of people accessing care at gender clinics in the United Kingdom every five or six years. Similarly, Zucker and colleagues (2008) reported a four- to five-fold increase in child and adolescent referrals to their Toronto, Canada clinic over a 30-year period.

The numbers yielded by studies such as these can be considered minimum estimates at best. The published figures are mostly derived from clinics where patients met criteria for severe gender dysphoria and had access to health care at those clinics. These estimates do not take into account that treatments offered in a particular clinic setting might not be perceived as affordable, useful, or acceptable by all self-identified gender dysphoric individuals in a given area. By counting only those people who present at clinics for a specific type of treatment, an unspecified number of gender dysphoric individuals are overlooked.

Other clinical observations (not yet firmly supported by systematic study) support the likelihood of a higher prevalence of gender dysphoria: (i) Previously unrecognized gender dysphoria is occasionally diagnosed when patients are seen with anxiety, depression, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, sexual disorders, and disorders of sex development (Cole, O'Boyle, Emory, & Meyer III, 1997). (ii) Some crossdressers, drag queens/kings or female/male impersonators, and gay and lesbian individuals may be experiencing gender dysphoria (Bullough & Bullough, 1993). (iii) The intensity of some people's gender dysphoria fluctuates below and above a clinical threshold (Docter, 1988). (iv) Gender nonconformity among FtM individuals tends to be relatively invisible in many cultures, particularly to Western health

professionals and researchers who have conducted most of the studies on which the current estimates of prevalence and incidence are based (Winter, 2009).

Overall, the existing data should be considered a starting point, and health care would benefit from more rigorous epidemiologic study in different locations worldwide.

V

Overview of Therapeutic Approaches for Gender Dysphoria

Advancements in the Knowledge and Treatment of Gender Dysphoria

In the second half of the 20th century, awareness of the phenomenon of gender dysphoria increased when health professionals began to provide assistance to alleviate gender dysphoria by supporting changes in primary and secondary sex characteristics through hormone therapy and surgery, along with a change in gender role. Although Harry Benjamin already acknowledged a spectrum of gender nonconformity (Benjamin, 1966), the initial clinical approach largely focused on identifying who was an appropriate candidate for sex reassignment to facilitate a physical change from male to female or female to male as completely as possible (e.g., Green & Fleming, 1990; Hastings, 1974). This approach was extensively evaluated and proved to be highly effective. Satisfaction rates across studies ranged from 87% of MtF patients to 97% of FtM patients (Green & Fleming, 1990), and regrets were extremely rare (1-1.5% of MtF patients and <1% of FtM patients; Pfäfflin, 1993). Indeed, hormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many people (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

As the field matured, health professionals recognized that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither (Bockting & Goldberg, 2006; Bockting, 2008; Lev, 2004). Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others, changes in gender role and expression are sufficient to alleviate

gender dysphoria. Some patients may need hormones, a possible change in gender role, but not surgery; others may need a change in gender role along with surgery, but not hormones. In other words, treatment for gender dysphoria has become more individualized.

As a generation of transsexual, transgender, and gender nonconforming individuals has come of age – many of whom have benefitted from different therapeutic approaches – they have become more visible as a community and demonstrated considerable diversity in their gender identities, roles, and expressions. Some individuals describe themselves not as gender nonconforming but as unambiguously cross-sexed (i.e., as a member of the other sex; Bockting, 2008). Other individuals affirm their unique gender identity and no longer consider themselves either male or female (Bornstein, 1994; Kimberly, 1997; Stone, 1991; Warren, 1993). Instead, they may describe their gender identity in specific terms such as transgender, bigender, or genderqueer, affirming their unique experience that may transcend a male/female binary understanding of gender (Bockting, 2008; Ekins & King, 2006; Nestle, Wilchins, & Howell, 2002). They may not experience their process of identity affirmation as a "transition," because they never fully embraced the gender role they were assigned at birth or because they actualize their gender identity, role, and expression in a way that does not involve a change from one gender role to another. For example, some youth identifying as genderqueer have always experienced their gender identity and role as such (genderqueer). Greater public visibility and awareness of gender diversity (Feinberg, 1996) has further expanded options for people with gender dysphoria to actualize an identity and find a gender role and expression that is comfortable for them.

Health professionals can assist gender dysphoric individuals with affirming their gender identity, exploring different options for expression of that identity, and making decisions about medical treatment options for alleviating gender dysphoria.

Options for Psychological and Medical Treatment of Gender Dysphoria

For individuals seeking care for gender dysphoria, a variety of therapeutic options can be considered. The number and type of interventions applied and the order in which these take place may differ from person to person (e.g., Bockting, Knudson, & Goldberg, 2006; Bolin, 1994; Rachlin, 1999; Rachlin, Green, & Lombardi, 2008; Rachlin, Hansbury, & Pardo, 2010). Treatments options include the following:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);

- Hormone therapy to feminize or masculinize the body;

- Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

Options for Social Support and Changes in Gender Expression

In addition (or as an alternative) to the psychological and medical treatment options described above, other options can be considered to help alleviate gender dysphoria, for example:

- Offline and online peer support resources, groups, or community organizations that provide avenues for social support and advocacy;
- Offline and online support resources for families and friends;
- Voice and communication therapy to help individuals develop verbal and non-verbal communication skills that facilitate comfort with their gender identity;
- Hair removal through electrolysis, laser treatment, or waxing;
- Breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks;
- Changes in name and gender marker on identity documents.

VI

Assessment and Treatment of Children and Adolescents with Gender Dysphoria

There are a number of differences in the phenomenology, developmental course, and treatment approaches for gender dysphoria in children, adolescents, and adults. In children and adolescents, a rapid and dramatic developmental process (physical, psychological, and sexual) is involved and

there is greater fluidity and variability in outcomes, particular in prepubertal children. Accordingly, this section of the *SOC* offers specific clinical guidelines for the assessment and treatment of gender dysphoric children and adolescents.

Differences between Children and Adolescents with Gender Dysphoria

An important difference between gender dysphoric children and adolescents is in the proportion for whom dysphoria persists into adulthood. Gender dysphoria during childhood does not inevitably continue into adulthood.[5] Rather, in follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6-23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12-27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).

In contrast, the persistence of gender dysphoria into adulthood appears to be much higher for adolescents. No formal prospective studies exist. However, in a follow-up study of 70 adolescents who were diagnosed with gender dysphoria and given puberty suppressing hormones, all continued with the actual sex reassignment, beginning with feminizing/masculinizing hormone therapy (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010).

Another difference between gender dysphoric children and adolescents is in the sex ratios for each age group. In clinically referred, gender dysphoric children under age 12, the male/female ratio ranges from 6:1 to 3:1 (Zucker, 2004). In clinically referred, gender dysphoric adolescents older than age 12, the male/female ratio is close to 1:1 (Cohen-Kettenis & Pfäfflin, 2003).

As discussed in section IV and by Zucker and Lawrence (2009), formal epidemiologic studies on gender dysphoria – in children, adolescents, and adults – are lacking. Additional research is needed to refine estimates of its prevalence and persistence in different populations worldwide.

5 Gender nonconforming behaviors in children may continue into adulthood, but such behaviors are not necessarily indicative of gender dysphoria and a need for treatment. As described in section III, gender dysphoria is not synonymous with diversity in gender expression.

Phenomenology in Children

Children as young as age two may show features that could indicate gender dysphoria. They may express a wish to be of the other sex and be unhappy about their physical sex characteristics and functions. In addition, they may prefer clothes, toys, and games that are commonly associated with the other sex and prefer playing with other-sex peers. There appears to be heterogeneity in these features: Some children demonstrate extremely gender nonconforming behavior and wishes, accompanied by persistent and severe discomfort with their primary sex characteristics. In other children, these characteristics are less intense or only partially present (Cohen-Kettenis et al., 2006; Knudson, De Cuypere, & Bockting, 2010a).

It is relatively common for gender dysphoric children to have co-existing internalizing disorders such as anxiety and depression (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; Wallien, Swaab, & Cohen-Kettenis, 2007; Zucker, Owen, Bradley, & Ameeriar, 2002). The prevalence of autistic spectrum disorders seems to be higher in clinically referred, gender dysphoric children than in the general population (de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010).

Phenomenology in Adolescents

In most children, gender dysphoria will disappear before or early in puberty. However, in some children these feelings will intensify and body aversion will develop or increase as they become adolescents and their secondary sex characteristics develop (Cohen-Kettenis, 2001; Cohen-Kettenis & Pfäfflin, 2003; Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008; Zucker & Bradley, 1995). Data from one study suggest that more extreme gender nonconformity in childhood is associated with persistence of gender dysphoria into late adolescence and early adulthood (Wallien & Cohen-Kettenis, 2008). Yet many adolescents and adults presenting with gender dysphoria do not report a history of childhood gender nonconforming behaviors (Docter, 1988; Landén, Wålinder, & Lundström, 1998). Therefore, it may come as a surprise to others (parents, other family members, friends, and community members) when a youth's gender dysphoria first becomes evident in adolescence.

Adolescents who experience their primary and/or secondary sex characteristics and their sex assigned at birth as inconsistent with their gender identity may be intensely distressed about it. Many, but not all, gender dysphoric adolescents have a strong wish for hormones and surgery. Increasing numbers of adolescents have already started living in their desired gender role upon entering high school (Cohen-Kettenis & Pfäfflin, 2003).

Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment – starting with GnRH analogues to suppress puberty in the first Tanner stages – differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker et al., in press). The percentages of treated adolescents are likely influenced by the organization of health care, insurance aspects, cultural differences, opinions of health professionals, and diagnostic procedures offered in different settings.

Inexperienced clinicians may mistake indications of gender dysphoria for delusions. Phenomenologically, there is a qualitative difference between the presentation of gender dysphoria and the presentation of delusions or other psychotic symptoms. The vast majority of children and adolescents with gender dysphoria are not suffering from underlying severe psychiatric illness such as psychotic disorders (Steensma, Biemond, de Boer, & Cohen-Kettenis, published online ahead of print January 7, 2011).

It is more common for adolescents with gender dysphoria to have co-existing internalizing disorders such as anxiety and depression, and/or externalizing disorders such as oppositional defiant disorder (de Vries et al., 2010). As in children, there seems to be a higher prevalence of autistic spectrum disorders in clinically referred, gender dysphoric adolescents than in the general adolescent population (de Vries et al., 2010).

Competency of Mental Health Professionals Working with Children or Adolescents with Gender Dysphoria

The following are recommended minimum credentials for mental health professionals who assess, refer, and offer therapy to children and adolescents presenting with gender dysphoria:

1. Meet the competency requirements for mental health professionals working with adults, as outlined in section VII;

2. Trained in childhood and adolescent developmental psychopathology;

3. Competent in diagnosing and treating the ordinary problems of children and adolescents.

Roles of Mental Health Professionals Working with Children and Adolescents with Gender Dysphoria

The roles of mental health professionals working with gender dysphoric children and adolescents may include the following:

1. Directly assess gender dysphoria in children and adolescents (see general guidelines for assessment, below).

2. Provide family counseling and supportive psychotherapy to assist children and adolescents with exploring their gender identity, alleviating distress related to their gender dysphoria, and ameliorating any other psychosocial difficulties.

3. Assess and treat any co-existing mental health concerns of children or adolescents (or refer to another mental health professional for treatment). Such concerns should be addressed as part of the overall treatment plan.

4. Refer adolescents for additional physical interventions (such as puberty suppressing hormones) to alleviate gender dysphoria. The referral should include documentation of an assessment of gender dysphoria and mental health, the adolescent's eligibility for physical interventions (outlined below), the mental health professional's relevant expertise, and any other information pertinent to the youth's health and referral for specific treatments.

5. Educate and advocate on behalf of gender dysphoric children, adolescents, and their families in their community (e.g., day care centers, schools, camps, other organizations). This is particularly important in light of evidence that children and adolescents who do not conform to socially prescribed gender norms may experience harassment in school (Grossman, D'Augelli, & Salter, 2006; Grossman, D'Augelli, Howell, & Hubbard, 2006; Sausa, 2005), putting them at risk for social isolation, depression, and other negative sequelae (Nuttbrock et al., 2010).

6. Provide children, youth, and their families with information and referral for peer support, such as support groups for parents of gender nonconforming and transgender children (Gold & MacNish, 2011; Pleak, 1999; Rosenberg, 2002).

Assessment and psychosocial interventions for children and adolescents are often provided within a multi-disciplinary gender identity specialty service. If such a multidisciplinary service is not available, a mental health professional should provide consultation and liaison arrangements with a pediatric endocrinologist for the purpose of assessment, education, and involvement in any decisions about physical interventions.

Psychological Assessment of Children and Adolescents

When assessing children and adolescents who present with gender dysphoria, mental health professionals should broadly conform to the following guidelines:

1. Mental health professionals should not dismiss or express a negative attitude towards nonconforming gender identities or indications of gender dysphoria. Rather, they should acknowledge the presenting concerns of children, adolescents, and their families; offer a thorough assessment for gender dysphoria and any co-existing mental health concerns; and educate clients and their families about therapeutic options, if needed. Acceptance and removal of secrecy can bring considerable relief to gender dysphoric children/adolescents and their families.

2. Assessment of gender dysphoria and mental health should explore the nature and characteristics of a child's or adolescent's gender identity. A psychodiagnostic and psychiatric assessment – covering the areas of emotional functioning, peer and other social relationships, and intellectual functioning/school achievement – should be performed. Assessment should include an evaluation of the strengths and weaknesses of family functioning. Emotional and behavioral problems are relatively common, and unresolved issues in a child's or youth's environment may be present (de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011; Di Ceglie & Thümmel, 2006; Wallien et al., 2007).

3. For adolescents, the assessment phase should also be used to inform youth and their families about the possibilities and limitations of different treatments. This is necessary for informed consent, but also important for assessment. The way that adolescents respond to information about the reality of sex reassignment can be diagnostically informative. Correct information may alter a youth's desire for certain treatment, if the desire was based on unrealistic expectations of its possibilities.

Psychological and Social Interventions for Children and Adolescents

When supporting and treating children and adolescents with gender dysphoria, health professionals should broadly conform to the following guidelines:

1. Mental health professionals should help families to have an accepting and nurturing response to the concerns of their gender dysphoric child or adolescent. Families play an important role in the psychological health and well-being of youth (Brill & Pepper, 2008; Lev, 2004). This also applies to peers and mentors from the community, who can be another source of social support.

2. Psychotherapy should focus on reducing a child's or adolescent's distress related to the gender dysphoria and on ameliorating any other psychosocial difficulties. For youth pursuing sex reassignment, psychotherapy may focus on supporting them before, during, and after reassignment. Formal evaluations of different psychotherapeutic approaches for this situation have not been published, but several counseling methods have been described (Cohen-Kettenis, 2006; de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006; Di Ceglie & Thümmel, 2006; Hill, Menvielle, Sica, & Johnson, 2010; Malpas, in press; Menvielle & Tuerk, 2002; Rosenberg, 2002; Vanderburgh, 2009; Zucker, 2006).

Treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success (Gelder & Marks, 1969; Greenson, 1964), particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

1. Families should be supported in managing uncertainty and anxiety about their child's or adolescent's psychosexual outcomes and in helping youth to develop a positive self-concept.

2. Mental health professionals should not impose a binary view of gender. They should give ample room for clients to explore different options for gender expression. Hormonal or surgical interventions are appropriate for some adolescents, but not for others.

3. Clients and their families should be supported in making difficult decisions regarding the extent to which clients are allowed to express a gender role that is consistent with their gender identity, as well as the timing of changes in gender role and possible social transition. For example, a client might attend school while undergoing social transition only partly (e.g., by wearing clothing and having a hairstyle that reflects gender identity) or completely (e.g., by also using a name and pronouns congruent with gender identity). Difficult issues include whether and when to inform other people of the client's situation, and how others in their lives should respond.

4. Health professionals should support clients and their families as educators and advocates in their interactions with community members and authorities such as teachers, school boards, and courts.

5. Mental health professionals should strive to maintain a therapeutic relationship with gender nonconforming children/adolescents and their families throughout any subsequent social changes or physical interventions. This ensures that decisions about gender expression and the treatment of gender dysphoria are thoughtfully and recurrently considered. The same reasoning applies if a child or adolescent has already socially changed gender role prior to being seen by a mental health professional.

Social Transition in Early Childhood

Some children state that they want to make a social transition to a different gender role long before puberty. For some children, this may reflect an expression of their gender identity. For others, this could be motivated by other forces. Families vary in the extent to which they allow their young children to make a social transition to another gender role. Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood. Outcomes research with children who completed early social transitions would greatly inform future clinical recommendations.

Mental health professionals can help families to make decisions regarding the timing and process of any gender role changes for their young children. They should provide information and help parents to weigh the potential benefits and challenges of particular choices. Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria (Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008). A change back to the original gender role can be highly distressing and even result in postponement of this second social transition on the child's part (Steensma & Cohen-Kettenis, 2011). For reasons such as these, parents may want to present this role change as an exploration of living in another gender role, rather than an irreversible situation. Mental health professionals can assist parents in identifying potential in-between solutions or compromises (e.g., only when on vacation). It is also important that parents explicitly let the child know that there is a way back.

Regardless of a family's decisions regarding transition (timing, extent), professionals should counsel and support them as they work through the options and implications. If parents do not allow their young child to make a gender role transition, they may need counseling to assist them with meeting their child's needs in a sensitive and nurturing way, ensuring that the child has ample possibilities to explore gender feelings and behavior in a safe environment. If parents do allow their young child to make a gender role transition, they may need counseling to facilitate a positive experience for their child. For example, they may need support in using correct pronouns, maintaining a safe and supportive environment for their transitioning child (e.g., in school, peer group settings), and communicating with other people in their child's life. In either case, as a child nears puberty, further assessment may be needed as options for physical interventions become relevant.

Physical Interventions for Adolescents

Before any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken, as outlined above. The duration of this exploration may vary considerably depending on the complexity of the situation.

Physical interventions should be addressed in the context of adolescent development. Some identity beliefs in adolescents may become firmly held and strongly expressed, giving a false impression of irreversibility. An adolescent's shift towards gender conformity can occur primarily to please the parents and may not persist or reflect a permanent change in gender dysphoria (Hembree et al., 2009; Steensma et al., published online ahead of print January 7, 2011).

Physical interventions for adolescents fall into three categories or stages (Hembree et al., 2009):

1. *Fully reversible interventions*. These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (most commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.

2. *Partially reversible interventions*. These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone).

3. *Irreversible interventions*. These are surgical procedures.

A staged process is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions.

Fully Reversible Interventions

Adolescents may be eligible for puberty suppressing hormones as soon as pubertal changes have begun. In order for adolescents and their parents to make an informed decision about pubertal delay, it is recommended that adolescents experience the onset of puberty to at least Tanner Stage 2. Some children may arrive at this stage at very young ages (e.g., 9 years of age). Studies

evaluating this approach only included children who were at least 12 years of age (Cohen-Kettenis, Schagen, Steensma, de Vries, & Delemarre-van de Waal, 2011; de Vries, Steensma et al., 2010; Delemarre-van de Waal, van Weissenbruch, & Cohen Kettenis, 2004; Delemarre-van de Waal & Cohen-Kettenis, 2006).

Two goals justify intervention with puberty suppressing hormones: (i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment.

Puberty suppression may continue for a few years, at which time a decision is made to either discontinue all hormone therapy or transition to a feminizing/masculinizing hormone regimen. Pubertal suppression does not inevitably lead to social transition or to sex reassignment.

Criteria for puberty suppressing hormones

In order for adolescents to receive puberty suppressing hormones, the following minimum criteria must be met:

1. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);

2. Gender dysphoria emerged or worsened with the onset of puberty;

3. Any co-existing psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment;

4. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

Regimens, monitoring, and risks for puberty suppression

For puberty suppression, adolescents with male genitalia should be treated with GnRH analogues, which stop luteinizing hormone secretion and therefore testosterone secretion. Alternatively, they may be treated with progestins (such as medroxyprogesterone) or with other medications that block testosterone secretion and/or neutralize testosterone action. Adolescents with female genitalia should be treated with GnRH analogues, which stop the production of estrogens and

progesterone. Alternatively, they may be treated with progestins (such as medroxyprogesterone). Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses. In both groups of adolescents, use of GnRH analogues is the preferred treatment (Hembree et al., 2009), but their high cost is prohibitive for some patients

During pubertal suppression, an adolescent's physical development should be carefully monitored – preferably by a pediatric endocrinologist – so that any necessary interventions can occur (e.g., to establish an adequate gender appropriate height, to improve iatrogenic low bone marrow density) (Hembree et al., 2009).

Early use of puberty suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. Intervention in early adolescence should be managed with pediatric endocrinological advice, when available. Adolescents with male genitalia who start GnRH analogues early in puberty should be informed that this could result in insufficient penile tissue for penile inversion vaginoplasty techniques (alternative techniques, such as the use of a skin graft or colon tissue, are available).

Neither puberty suppression nor allowing puberty to occur is a neutral act. On the one hand, functioning in later life can be compromised by the development of irreversible secondary sex characteristics during puberty and by years spent experiencing intense gender dysphoria. On the other hand, there are concerns about negative physical side effects of GnRH analog use (e.g., on bone development and height). Although the very first results of this approach (as assessed for adolescents followed over 10 years) are promising (Cohen-Kettenis et al., 2011; Delemarre-van de Waal & Cohen-Kettenis, 2006), the long-term effects can only be determined when the earliest treated patients reach the appropriate age.

Partially Reversible Interventions

Adolescents may be eligible to begin feminizing/masculinizing hormone therapy, preferably with parental consent. In many countries, 16-year-olds are legal adults for medical decision-making and do not require parental consent. Ideally, treatment decisions should be made among the adolescent, the family, and the treatment team.

Regimens for hormone therapy in gender dysphoric adolescents differ substantially from those used in adults (Hembree et al., 2009). The hormone regimens for youth are adapted to account for the somatic, emotional, and mental development that occurs throughout adolescence (Hembree et al., 2009).

Irreversible Interventions

Genital surgery should not be carried out until (i) patients reach the legal age of majority in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.

Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression.

Risks of Withholding Medical Treatment for Adolescents

Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence (Nuttbrock et al., 2010), withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.

VII
Mental Health

Transsexual, transgender, and gender nonconforming people might seek the assistance of a mental health professional for any number of reasons. Regardless of a person's reason for seeking care, mental health professionals should have familiarity with gender nonconformity, act with appropriate cultural competence, and exhibit sensitivity in providing care.

This section of the *SOC* focuses on the role of mental health professionals in the care of adults seeking help for gender dysphoria and related concerns. Professionals working with gender dysphoric children, adolescents, and their families should consult section VI.

Competency of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

The training of mental health professionals competent to work with gender dysphoric adults rests upon basic general clinical competence in the assessment, diagnosis, and treatment of mental health concerns. Clinical training may occur within any discipline that prepares mental health professionals for clinical practice, such as psychology, psychiatry, social work, mental health counseling, marriage and family therapy, nursing, or family medicine with specific training in behavioral health and counseling. The following are recommended minimum credentials for mental health professionals who work with adults presenting with gender dysphoria:

1. A master's degree or its equivalent in a clinical behavioral science field. This degree or a more advanced one should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.

2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes.

3. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria.

4. Documented supervised training and competence in psychotherapy or counseling.

5. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.

6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

In addition to the minimum credentials above, it is recommended that mental health professionals develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy, and public policy issues relevant to these clients and their families. Additionally, knowledge about sexuality, sexual health concerns, and the assessment and treatment of sexual disorders is preferred.

Mental health professionals who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria.

Tasks of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

Mental health professionals may serve transsexual, transgender, and gender nonconforming individuals and their families in many ways, depending on a client's needs. For example, mental health professionals may serve as a psychotherapist, counselor, or family therapist, or as a diagnostician/assessor, advocate, or educator.

Mental health professionals should determine a client's reasons for seeking professional assistance. For example, a client may be presenting for any combination of the following health care services: psychotherapeutic assistance to explore gender identity and expression or to facilitate a coming out process; assessment and referral for feminizing/masculinizing medical interventions; psychological support for family members (partners, children, extended family); or psychotherapy unrelated to gender concerns or other professional services.

Below are general guidelines for common tasks that mental health professionals may fulfill in working with adults who present with gender dysphoria.

Tasks Related to Assessment and Referral

1. Assess gender dysphoria

Mental health professionals assess clients' gender dysphoria in the context of an evaluation of their psychosocial adjustment (Bockting et al., 2006; Lev, 2004, 2009). The evaluation includes, at a minimum, assessment of gender identity and gender dysphoria, history and development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on mental health, and the availability of support from family, friends, and peers (for example, in person or online contact with other transsexual, transgender, or gender nonconforming individuals or groups). The evaluation may result in no diagnosis, in a formal diagnosis related to gender dysphoria, and/or in other diagnoses that describe aspects of the client's health and psychosocial adjustment. The role

of mental health professionals includes making reasonably sure that the gender dysphoria is not secondary to or better accounted for by other diagnoses.

Mental health professionals with the competencies described above (hereafter called "a qualified mental health professional") are best prepared to conduct this assessment of gender dysphoria. However, this task may instead be conducted by another type of health professional who has appropriate training in behavioral health and is competent in the assessment of gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy. This professional may be the prescribing hormone therapy provider or a member of that provider's health care team.

2. Provide information regarding options for gender identity and expression and possible medical interventions

An important task of mental health professionals is to educate clients regarding the diversity of gender identities and expressions and the various options available to alleviate gender dysphoria. Mental health professionals then may facilitate a process (or refer elsewhere) in which clients explore these various options, with the goals of finding a comfortable gender role and expression and becoming prepared to make a fully informed decision about available medical interventions, if needed. This process may include referral for individual, family, and group therapy and/or to community resources and avenues for peer support. The professional and the client discuss the implications, both short- and long-term, of any changes in gender role and use of medical interventions. These implications can be psychological, social, physical, sexual, occupational, financial, and legal (Bockting et al., 2006; Lev, 2004).

This task is also best conducted by a qualified mental health professional, but may be conducted by another health professional with appropriate training in behavioral health and with sufficient knowledge about gender nonconforming identities and expressions and about possible medical interventions for gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy.

3. Assess, diagnose, and discuss treatment options for co-existing mental health concerns

Clients presenting with gender dysphoria may struggle with a range of mental health concerns (Gómez-Gil, Trilla, Salamero, Godás, & Valdés, 2009; Murad et al., 2010) whether related or unrelated to what is often a long history of gender dysphoria and/or chronic minority stress. Possible concerns include anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, personality disorders, eating disorders, psychotic disorders, and autistic spectrum disorders (Bockting et al., 2006; Nuttbrock et al., 2010; Robinow, 2009). Mental health professionals should screen for these and other mental health concerns and incorporate

the identified concerns into the overall treatment plan. These concerns can be significant sources of distress and, if left untreated, can complicate the process of gender identity exploration and resolution of gender dysphoria (Bockting et al., 2006; Fraser, 2009a; Lev, 2009). Addressing these concerns can greatly facilitate the resolution of gender dysphoria, possible changes in gender role, the making of informed decisions about medical interventions, and improvements in quality of life.

Some clients may benefit from psychotropic medications to alleviate symptoms or treat co-existing mental health concerns. Mental health professionals are expected to recognize this and either provide pharmacotherapy or refer to a colleague who is qualified to do so. The presence of co-existing mental health concerns does not necessarily preclude possible changes in gender role or access to feminizing/masculinizing hormones or surgery; rather, these concerns need to be optimally managed prior to or concurrent with treatment of gender dysphoria. In addition, clients should be assessed for their ability to provide educated and informed consent for medical treatments.

Qualified mental health professionals are specifically trained to assess, diagnose, and treat (or refer to treatment for) these co-existing mental health concerns. Other health professionals with appropriate training in behavioral health, particularly when functioning as part of a multidisciplinary specialty team providing access to feminizing/masculinizing hormone therapy, may also screen for mental health concerns and, if indicated, provide referral for comprehensive assessment and treatment by a qualified mental health professional.

4. If applicable, assess eligibility, prepare, and refer for hormone therapy

The *SOC* provide criteria to guide decisions regarding feminizing/masculinizing hormone therapy (outlined in section VIII and Appendix C). Mental health professionals can help clients who are considering hormone therapy to be both psychologically prepared (for example, has made a fully informed decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has been evaluated by a physician to rule out or address medical contraindications to hormone use; has considered the psychosocial implications). If clients are of childbearing age, reproductive options (section IX) should be explored before initiating hormone therapy.

It is important for mental health professionals to recognize that decisions about hormones are first and foremost the client's decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for feminizing/masculinizing hormone therapy

People may approach a specialized provider in any discipline to pursue feminizing/masculinizing hormone therapy. However, transgender health care is an interdisciplinary field, and coordination of care and referral among a client's overall care team is recommended.

Hormone therapy can be initiated with a referral from a qualified mental health professional. Alternatively, a health professional who is appropriately trained in behavioral health and competent in the assessment of gender dysphoria may assess eligibility, prepare, and refer the patient for hormone therapy, particularly in the absence of significant co-existing mental health concerns and when working in the context of a multidisciplinary specialty team. The referring health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Health professionals who recommend hormone therapy share the ethical and legal responsibility for that decision with the physician who provides the service.

The recommended content of the referral letter for feminizing/masculinizing hormone therapy is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;

3. The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;

4. An explanation that the criteria for hormone therapy have been met, and a brief description of the clinical rationale for supporting the client's request for hormone therapy;

5. A statement about the fact that informed consent has been obtained from the patient;

6. A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

5. If applicable, assess eligibility, prepare, and refer for surgery

The *SOC* also provide criteria to guide decisions regarding breast/chest surgery and genital surgery (outlined in section XI and Appendix C). Mental health professionals can help clients who are considering surgery to be both psychologically prepared (for example, has made a fully informed

decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has made an informed choice about a surgeon to perform the procedure; has arranged aftercare). If clients are of childbearing age, reproductive options (section IX) should be explored before undergoing genital surgery.

The *SOC* do not state criteria for other surgical procedures, such as feminizing or masculinizing facial surgery; however, mental health professionals can play an important role in helping their clients to make fully informed decisions about the timing and implications of such procedures in the context of the overall coming out or transition process.

It is important for mental health professionals to recognize that decisions about surgery are first and foremost a client's decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for surgery

Surgical treatments for gender dysphoria can be initiated with a referral (one or two, depending on the type of surgery) from a qualified mental health professional. The mental health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Mental health professionals who recommend surgery share the ethical and legal responsibility for that decision with the surgeon.

- One referral from a qualified mental health professional is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty).

- Two referrals – from qualified mental health professionals who have independently assessed the patient – are needed for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries). If the first referral is from the patient's psychotherapist, the second referral should be from a person who has only had an evaluative role with the patient. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent. Each referral letter, however, is expected to cover the same topics in the areas outlined below.

The recommended content of the referral letters for surgery is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;

3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;

4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;

5. A statement about the fact that informed consent has been obtained from the patient;

6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

Relationship of Mental Health Professionals with Hormone-Prescribing Physicians, Surgeons, and other Health Professionals

It is ideal for mental health professionals to perform their work and periodically discuss progress and obtain peer consultation from other professionals (both in mental health care and other health disciplines) who are competent in the assessment and treatment of gender dysphoria. The relationship among professionals involved in a client's health care should remain collaborative, with coordination and clinical dialogue taking place as needed. Open and consistent communication may be necessary for consultation, referral, and management of postoperative concerns.

Tasks Related to Psychotherapy

1. Psychotherapy is not an absolute requirement for hormone therapy and surgery

A mental health screening and/or assessment as outlined above is needed for referral to hormonal and surgical treatments for gender dysphoria. In contrast, psychotherapy – although highly recommended – is not a requirement.

The *SOC* do not recommend a minimum number of psychotherapy sessions prior to hormone therapy or surgery. The reasons for this are multifaceted (Lev, 2009). First, a minimum number of sessions tends to be construed as a hurdle, which discourages the genuine opportunity for personal growth. Second, mental health professionals can offer important support to clients throughout all

phases of exploration of gender identity, gender expression, and possible transition – not just prior to any possible medical interventions. Third, clients differ in their abilities to attain similar goals in a specified time period.

2. Goals of psychotherapy for adults with gender concerns

The general goal of psychotherapy is to find ways to maximize a person's overall psychological well-being, quality of life, and self-fulfillment. Psychotherapy is not intended to alter a person's gender identity; rather, psychotherapy can help an individual to explore gender concerns and find ways to alleviate gender dysphoria, if present (Bockting et al., 2006; Bockting & Coleman, 2007; Fraser, 2009a; Lev, 2004). Typically, the overarching treatment goal is to help transsexual, transgender, and gender nonconforming individuals achieve long-term comfort in their gender identity expression, with realistic chances for success in their relationships, education, and work. For additional details, see Fraser (Fraser, 2009c).

Therapy may consist of individual, couple, family, or group psychotherapy, the latter being particularly important to foster peer support.

3. Psychotherapy for transsexual, transgender, and gender nonconforming clients, including counseling and support for changes in gender role

Finding a comfortable gender role is, first and foremost, a psychosocial process. Psychotherapy can be invaluable in assisting transsexual, transgender, and gender nonconforming individuals with all of the following: (i) clarifying and exploring gender identity and role, (ii) addressing the impact of stigma and minority stress on one's mental health and human development, and (iii) facilitating a coming out process (Bockting & Coleman, 2007; Devor, 2004; Lev, 2004), which for some individuals may include changes in gender role expression and the use of feminizing/masculinizing medical interventions.

Mental health professionals can provide support and promote interpersonal skills and resilience in individuals and their families as they navigate a world that often is ill prepared to accommodate and respect transgender, transsexual, and gender nonconforming people. Psychotherapy can also aid in alleviating any co-existing mental health concerns (e.g., anxiety, depression) identified during screening and assessment.

For transsexual, transgender, and gender nonconforming individuals who plan to change gender roles permanently and make a social gender role transition, mental health professionals can facilitate the development of an individualized plan with specific goals and timelines. While the experience of changing one's gender role differs from person to person, the social aspects of the experience are usually challenging – often more so than the physical aspects. Because changing

gender role can have profound personal and social consequences, the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role.

Many transsexual, transgender, and gender nonconforming people will present for care without ever having been related to or accepted in the gender role that is most congruent with their gender identity. Mental health professionals can help these clients to explore and anticipate the implications of changes in gender role, and to pace the process of implementing these changes. Psychotherapy can provide a space for clients to begin to express themselves in ways that are congruent with their gender identity and, for some clients, overcome fear about changes in gender expression. Calculated risks can be taken outside of therapy to gain experience and build confidence in the new role. Assistance with coming out to family and community (friends, school, workplace) can be provided.

Other transsexual, transgender, and gender nonconforming individuals will present for care already having acquired experience (minimal, moderate, or extensive) living in a gender role that differs from that associated with their birth-assigned sex. Mental health professionals can help these clients to identify and work through potential challenges and foster optimal adjustment as they continue to express changes in their gender role.

4. Family therapy or support for family members

Decisions about changes in gender role and medical interventions for gender dysphoria have implications for not only clients, but also their families (Emerson & Rosenfeld, 1996; Fraser, 2009a; Lev, 2004). Mental health professionals can assist clients with making thoughtful decisions about communicating with family members and others about their gender identity and treatment decisions. Family therapy may include work with spouses or partners, as well as with children and other members of a client's extended family.

Clients may also request assistance with their relationships and sexual health. For example, they may want to explore their sexuality and intimacy related concerns.

Family therapy might be offered as part of the client's individual therapy and, if clinically appropriate, by the same provider. Alternatively, referrals can be made to other therapists with relevant expertise to work with family members, or to sources of peer support (e.g., online or offline support networks of partners or families).

5. Follow-up care throughout life

Mental health professionals may work with clients and their families at many stages of their lives. Psychotherapy may be helpful at different times and for various issues throughout the life cycle.

6. Etherapy, online counseling, or distance counseling

Online or etherapy has been shown to be particularly useful for people who have difficulty accessing competent psychotherapeutic treatment and who may experience isolation and stigma (Derrig-Palumbo & Zeine, 2005; Fenichel et al., 2004; Fraser, 2009b). By extrapolation, etherapy may be a useful modality for psychotherapy with transsexual, transgender, and gender nonconforming people. Etherapy offers opportunities for potentially enhanced, expanded, creative, and tailored delivery of services; however, as a developing modality it may also carry unexpected risk. Telemedicine guidelines are clear in some disciplines in some parts of the United States (Fraser, 2009b; Maheu, Pulier, Wilhelm, McMenamin, & Brown-Connolly, 2005) but not all; the international situation is even less defined (Maheu et al., 2005). Until sufficient evidence-based data on this use of etherapy is available, caution in its use is advised.

Mental health professionals engaging in etherapy are advised to stay current with their particular licensing board, professional association, and country's regulations, as well as the most recent literature pertaining to this rapidly evolving medium. A more thorough description of the potential uses, processes, and ethical concerns related to etherapy has been published (Fraser, 2009b).

Other Tasks of the Mental Health Professional

1. Educate and advocate on behalf of clients within their community (schools, workplaces, other organizations) and assist clients with making changes in identity documents

Transsexual, transgender, and gender nonconforming people may face challenges in their professional, educational, and other types of settings as they actualize their gender identity and expression (Lev, 2004, 2009). Mental health professionals can play an important role by educating people in these settings regarding gender nonconformity and by advocating on behalf of their clients (Currah, Juang, & Minter, 2006) (Currah & Minter, 2000). This role may involve consultation with school counselors, teachers, and administrators, human resources staff, personnel managers and employers, and representatives from other organizations and institutions. In addition, health providers may be called upon to support changes in a client's name and/or gender marker on identity documents such as passports, driver's licenses, birth certificates, and diplomas.

2. Provide information and referral for peer support

For some transsexual, transgender, and gender nonconforming people, an experience in peer support groups may be more instructive regarding options for gender expression than anything individual psychotherapy could offer (Rachlin, 2002). Both experiences are potentially valuable, and all people exploring gender issues should be encouraged to participate in community activities, if possible. Resources for peer support and information should be made available.

Culture and its Ramifications for Assessment and Psychotherapy

Health professionals work in enormously different environments across the world. Forms of distress that cause people to seek professional assistance in any culture are understood and classified by people in terms that are products of their own cultures (Frank & Frank, 1993). Cultural settings also largely determine how such conditions are understood by mental health professionals. Cultural differences related to gender identity and expression can affect patients, mental health professionals, and accepted psychotherapy practice. WPATH recognizes that the *SOC* have grown out of a Western tradition and may need to be adapted depending on the cultural context.

Ethical Guidelines Related to Mental Health Care

Mental health professionals need to be certified or licensed to practice in a given country according to that country's professional regulations (Fraser, 2009b; Pope & Vasquez, 2011). Professionals must adhere to the ethical codes of their professional licensing or certifying organizations in all of their work with transsexual, transgender, and gender nonconforming clients.

Treatment aimed at trying to change a person's gender identity and lived gender expression to become more congruent with sex assigned at birth has been attempted in the past (Gelder & Marks, 1969; Greenson, 1964), yet without success, particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

If mental health professionals are uncomfortable with or inexperienced in working with transsexual, transgender, and gender nonconforming individuals and their families, they should refer clients to a competent provider or, at minimum, consult with an expert peer. If no local practitioners are available, consultation may be done via telehealth methods, assuming local requirements for distance consultation are met.

Issues of Access to Care

Qualified mental health professionals are not universally available; thus, access to quality care might be limited. WPATH aims to improve access and provides regular continuing education opportunities to train professionals from various disciplines to provide quality, transgender-specific health care. Providing mental health care from a distance through the use of technology may be one way to improve access (Fraser, 2009b).

In many places around the world, access to health care for transsexual, transgender, and gender nonconforming people is also limited by a lack of health insurance or other means to pay for needed care. WPATH urges health insurance companies and other third-party payers to cover the medically necessary treatment to alleviate gender dysphoria (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

When faced with a client who is unable to access services, referral to available peer support resources (offline and online) is recommended. Finally, harm reduction approaches might be indicated to assist clients with making healthy decisions to improve their lives.

VIII
Hormone Therapy

Medical Necessity of Hormone Therapy

Feminizing/masculinizing hormone therapy – the administration of exogenous endocrine agents to induce feminizing or masculinizing changes – is a medically necessary intervention for many transsexual, transgender, and gender nonconforming individuals with gender dysphoria (Newfield, Hart, Dibble, & Kohler, 2006; Pfäfflin & Junge, 1998). Some people seek maximum feminization/masculinization, while others experience relief with an androgynous presentation resulting from hormonal minimization of existing secondary sex characteristics (Factor & Rothblum, 2008). Evidence for the psychosocial outcomes of hormone therapy is summarized in Appendix D.

Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Hormone therapy can provide significant comfort to patients who do not wish to make a social gender role transition or undergo surgery, or who are unable to do so (Meyer III, 2009).

Hormone therapy is a recommended criterion for some, but not all, surgical treatments for gender dysphoria (see section XI and Appendix C).

Criteria for Hormone Therapy

Initiation of hormone therapy may be undertaken after a psychosocial assessment has been conducted and informed consent has been obtained by a qualified health professional, as outlined in section VII of the *SOC*. A referral is required from the mental health professional who performed the assessment, unless the assessment was done by a hormone provider who is also qualified in this area.

The criteria for hormone therapy are as follows:

1. Persistent, well-documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country (if younger, follow the *Standards of Care* outlined in section VI);

4. If significant medical or mental health concerns are present, they must be reasonably well-controlled.

As noted in section VII of the *SOC*, the presence of co-existing mental health concerns does not necessarily preclude access to feminizing/masculinizing hormones; rather, these concerns need to be managed prior to or concurrent with treatment of gender dysphoria.

In selected circumstances, it can be acceptable practice to provide hormones to patients who have not fulfilled these criteria. Examples include facilitating the provision of monitored therapy using hormones of known quality as an alternative to illicit or unsupervised hormone use or to patients who have already established themselves in their affirmed gender and who have a history of prior hormone use. It is unethical to deny availability or eligibility for hormone therapy solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis B or C.

In rare cases, hormone therapy may be contraindicated due to serious individual health conditions. Health professionals should assist these patients with accessing non-hormonal interventions for gender dysphoria. A qualified mental health professional familiar with the patient is an excellent resource in these circumstances.

Informed Consent

Feminizing/masculinizing hormone therapy may lead to irreversible physical changes. Thus, hormone therapy should be provided only to those who are legally able to provide informed consent. This includes people who have been declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions (see also Bockting et al., 2006). Providers should document in the medical record that comprehensive information has been provided and understood about all relevant aspects of the hormone therapy, including both possible benefits and risks and the impact on reproductive capacity.

Relationship between the Standards of Care and Informed Consent Model Protocols

A number of community health centers in the United States have developed protocols for providing hormone therapy based on an approach that has become known as the Informed Consent Model (Callen Lorde Community Health Center, 2000, 2011; Fenway Community Health Transgender Health Program, 2007; Tom Waddell Health Center, 2006). These protocols are consistent with the guidelines presented in the WPATH *Standards of Care, Version 7*. The *SOC* are flexible clinical guidelines; they allow for tailoring of interventions to the needs of the individual receiving services and for tailoring of protocols to the approach and setting in which these services are provided (Ehrbar & Gorton, 2010).

Obtaining informed consent for hormone therapy is an important task of providers to ensure that patients understand the psychological and physical benefits and risks of hormone therapy, as well as its psychosocial implications. Providers prescribing the hormones or health professionals recommending the hormones should have the knowledge and experience to assess gender dysphoria. They should inform individuals of the particular benefits, limitations, and risks of hormones, given the patient's age, previous experience with hormones, and concurrent physical or mental health concerns.

Screening for and addressing acute or current mental health concerns is an important part of the informed consent process. This may be done by a mental health professional or by an appropriately trained prescribing provider (see section VII of the *SOC*). The same provider or another appropriately trained member of the health care team (e.g., a nurse) can address the psychosocial implications of taking hormones when necessary (e.g., the impact of masculinization/feminization on how one is perceived and its potential impact on relationships with family, friends, and coworkers). If indicated, these providers will make referrals for psychotherapy and for the assessment and treatment of co-existing mental health concerns such as anxiety or depression.

The difference between the Informed Consent Model and *SOC, Version 7* is that the *SOC* puts greater emphasis on the important role that mental health professionals can play in alleviating gender dysphoria and facilitating changes in gender role and psychosocial adjustment. This may include a comprehensive mental health assessment and psychotherapy, when indicated. In the Informed Consent Model, the focus is on obtaining informed consent as the threshold for the initiation of hormone therapy in a multidisciplinary, harm-reduction environment. Less emphasis is placed on the provision of mental health care until the patient requests it, unless significant mental health concerns are identified that would need to be addressed before hormone prescription.

Physical Effects of Hormone Therapy

Feminizing/masculinizing hormone therapy will induce physical changes that are more congruent with a patient's gender identity.

- In FtM patients, the following physical changes are expected to occur: deepened voice, clitoral enlargement (variable), growth in facial and body hair, cessation of menses, atrophy of breast tissue, increased libido, and decreased percentage of body fat compared to muscle mass.

- In MtF patients, the following physical changes are expected to occur: breast growth (variable), decreased libido and erections, decreased testicular size, and increased percentage of body fact compared to muscle mass.

Most physical changes, whether feminizing or masculinizing, occur over the course of two years. The amount of physical change and the exact timeline of effects can be highly variable. Tables 1a and 1b outline the approximate time course of these physical changes.

TABLE 1A: EFFECTS AND EXPECTED TIME COURSE OF MASCULINIZING HORMONES [A]

Effect	Expected Onset[B]	Expected Maximum Effect[B]
Skin oiliness/acne	1-6 months	1-2 years
Facial/body hair growth	3-6 months	3-5 years
Scalp hair loss	>12 months[C]	variable
Increased muscle mass/strength	6-12 months	2-5 years[D]
Body fat redistribution	3-6 months	2-5 years
Cessation of menses	2-6 months	n/a
Clitoral enlargement	3-6 months	1-2 years
Vaginal atrophy	3-6 months	1-2 years
Deepened voice	3-12 months	1-2 years

[A] Adapted with permission from Hembree et al.(2009). *Copyright 2009, The Endocrine Society.*
[B] Estimates represent published and unpublished clinical observations.
[C] Highly dependent on age and inheritance; may be minimal.
[D] Significantly dependent on amount of exercise.

TABLE 1B: EFFECTS AND EXPECTED TIME COURSE OF FEMINIZING HORMONES [A]

Effect	Expected Onset[B]	Expected Maximum Effect[B]
Body fat redistribution	3-6 months	2-5 years
Decreased muscle mass/ strength	3-6 months	1-2 years[C]
Softening of skin/decreased oiliness	3-6 months	unknown
Decreased libido	1-3 months	1-2 years
Decreased spontaneous erections	1-3 months	3-6 months
Male sexual dysfunction	variable	variable
Breast growth	3-6 months	2-3 years
Decreased testicular volume	3-6 months	2-3 years
Decreased sperm production	variable	variable
Thinning and slowed growth of body and facial hair	6-12 months	> 3 years[D]
Male pattern baldness	No regrowth, loss stops 1-3 months	1-2 years

[A] Adapted with permission from Hembree et al. (2009). *Copyright 2009, The Endocrine Society.*
[B] Estimates represent published and unpublished clinical observations.
[C] Significantly dependent on amount of exercise.
[D] Complete removal of male facial and body hair requires electrolysis, laser treatment, or both.

The degree and rate of physical effects depends in part on the dose, route of administration, and medications used, which are selected in accordance with a patient's specific medical goals (e.g., changes in gender role expression, plans for sex reassignment) and medical risk profile. There is no current evidence that response to hormone therapy – with the possible exception of voice deepening in FtM persons – can be reliably predicted based on age, body habitus, ethnicity, or family appearance. All other factors being equal, there is no evidence to suggest that any medically approved type or method of administering hormones is more effective than any other in producing the desired physical changes.

Risks of Hormone Therapy

All medical interventions carry risks. The likelihood of a serious adverse event is dependent on numerous factors: the medication itself, dose, route of administration, and a patient's clinical characteristics (age, co-morbidities, family history, health habits). It is thus impossible to predict whether a given adverse effect will happen in an individual patient.

The risks associated with feminizing/masculinizing hormone therapy for the transsexual, transgender, and gender nonconforming population as a whole are summarized in Table 2. Based on the level of evidence, risks are categorized as follows: (i) likely increased risk with hormone therapy, (ii) possibly increased risk with hormone therapy, or (iii) inconclusive or no increased risk. Items in the last category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Additional detail about these risks can be found in Appendix B, which is based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (Dahl, Feldman, Goldberg, & Jaberi, 2006; Ettner, Monstrey, & Eyler, 2007).

TABLE 2: RISKS ASSOCIATED WITH HORMONE THERAPY. BOLDED ITEMS ARE CLINICALLY SIGNIFICANT

Risk Level	Feminizing hormones	Masculinizing hormones
Likely increased risk	Venous thromboembolic disease[A] Gallstones Elevated liver enzymes Weight gain Hypertriglyceridemia	Polycythemia Weight gain Acne Androgenic alopecia (balding) Sleep apnea
Likely increased risk with presence of additional risk factors[B]	Cardiovascular disease	
Possible increased risk	Hypertension Hyperprolactinemia or prolactinom[A]	Elevated liver enzymes Hyperlipidemia
Possible increased risk with presence of additional risk factors[B]	Type 2 diabetes[A]	Destabilization of certain psychiatric disorders[C] Cardiovascular disease Hypertension Type 2 diabetes
No increased risk or inconclusive	Breast cancer	Loss of bone density Breast cancer Cervical cancer Ovarian cancer Uterine cancer

[A] Risk is greater with oral estrogen administration than with transdermal estrogen administration.
[B] Additional risk factors include age.
[C] Includes bipolar, schizoaffective, and other disorders that may include manic or psychotic symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone.

Competency of Hormone-Prescribing Physicians, Relationship with Other Health Professionals

Feminizing/masculinizing hormone therapy is best undertaken in the context of a complete approach to health care that includes comprehensive primary care and a coordinated approach to psychosocial issues (Feldman & Safer, 2009). While psychotherapy or ongoing counseling is not required for the initiation of hormone therapy, if a therapist is involved, then regular communication among health professionals is advised (with the patient's consent) to ensure that the transition process is going well, both physically and psychosocially.

With appropriate training, feminizing/masculinizing hormone therapy can be managed by a variety of providers, including nurse practitioners and primary care physicians (Dahl et al., 2006). Medical visits relating to hormone maintenance provide an opportunity to deliver broader care to a population that is often medically underserved (Clements, Wilkinson, Kitano, & Marx, 1999; Feldman, 2007; Xavier, 2000). Many of the screening tasks and management of co-morbidities associated with long-term hormone use, such as cardiovascular risk factors and cancer screening, fall more uniformly within the scope of primary care rather than specialist care (American Academy of Family Physicians, 2005; Eyler, 2007; World Health Organization, 2008), particularly in locations where dedicated gender teams or specialized physicians are not available.

Given the multidisciplinary needs of transsexual, transgender, and gender nonconforming people seeking hormone therapy, as well as the difficulties associated with fragmentation of care in general (World Health Organization, 2008), WPATH strongly encourages the increased training and involvement of primary care providers in the area of feminizing/masculinizing hormone therapy. If hormones are prescribed by a specialist, there should be close communication with the patient's primary care provider. Conversely, an experienced hormone provider or endocrinologist should be involved if the primary care physician has no experience with this type of hormone therapy, or if the patient has a pre-existing metabolic or endocrine disorder that could be affected by endocrine therapy.

While formal training programs in transgender medicine do not yet exist, hormone providers have a responsibility to obtain appropriate knowledge and experience in this field. Clinicians can increase their experience and comfort in providing feminizing/masculinizing hormone therapy by co-managing care or consulting with a more experienced provider, or by providing more limited types of hormone therapy before progressing to initiation of hormone therapy. Because this field of medicine is evolving, clinicians should become familiar and keep current with the medical literature, and discuss emerging issues with colleagues. Such discussions might occur through networks established by WPATH and other national/local organizations.

Responsibilities of Hormone-Prescribing Physicians

In general, clinicians who prescribe hormone therapy should engage in the following tasks:

1. Perform an initial evaluation that includes discussion of a patient's physical transition goals, health history, physical examination, risk assessment, and relevant laboratory tests.

2. Discuss with patients the expected effects of feminizing/masculinizing medications and the possible adverse health effects. These effects can include a reduction in fertility (Feldman & Safer, 2009; Hembree et al., 2009). Therefore, reproductive options should be discussed with patients before starting hormone therapy (see section IX).

3. Confirm that patients have the capacity to understand the risks and benefits of treatment and are capable of making an informed decision about medical care.

4. Provide ongoing medical monitoring, including regular physical and laboratory examination to monitor hormone effectiveness and side effects.

5. Communicate as needed with a patient's primary care provider, mental health professional, and surgeon.

6. If needed, provide patients with a brief written statement indicating that they are under medical supervision and care that includes feminizing/masculinizing hormone therapy. Particularly during the early phases of hormone treatment, a patient may wish to carry this statement at all times to help prevent difficulties with the police and other authorities.

Depending on the clinical situation for providing hormones (see below), some of these responsibilities are less relevant. Thus, the degree of counseling, physical examinations, and laboratory evaluations should be individualized to a patient's needs.

Clinical Situations for Hormone Therapy

There are circumstances in which clinicians may be called upon to provide hormones without necessarily initiating or maintaining long-term feminizing/masculinizing hormone therapy. By acknowledging these different clinical situations (see below, from least to highest level of complexity), it may be possible to involve clinicians in feminizing/masculinizing hormone therapy who might not otherwise feel able to offer this treatment.

1. Bridging

Whether prescribed by another clinician or obtained through other means (e.g., purchased over the internet), patients may present for care already on hormone therapy. Clinicians can provide a limited (1-6 month) prescription for hormones while helping patients find a provider who can prescribe long-term hormone therapy. Providers should assess a patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated (Dahl et al., 2006; Feldman & Safer, 2009). If hormones were previously prescribed, medical records should be requested (with the patient's permission) to obtain the results of baseline examinations and laboratory tests and any adverse events. Hormone providers should also communicate with any mental health professional who is currently involved in a patient's care. If a patient has never had a psychosocial assessment as recommended by the *SOC* (see section VII), clinicians should refer the patient to a qualified mental health professional if appropriate and feasible (Feldman & Safer, 2009). Providers who prescribe bridging hormones need to work with patients to establish limits as to the duration of bridging therapy.

2. Hormone therapy following gonad removal

Hormone replacement with estrogen or testosterone is usually continued lifelong after an oophorectomy or orchiectomy, unless medical contraindications arise. Because hormone doses are often decreased after these surgeries (Basson, 2001; Levy, Crown, & Reid, 2003; Moore, Wisniewski, & Dobs, 2003) and only adjusted for age and co-morbid health concerns, hormone management in this situation is quite similar to hormone replacement in any hypogonadal patient.

3. Hormone maintenance prior to gonad removal

Once patients have achieved maximal feminizing/masculinizing benefits from hormones (typically two or more years), they remain on a maintenance dose. The maintenance dose is then adjusted for changes in health conditions, aging, or other considerations such as lifestyle changes (Dahl et al., 2006). When a patient on maintenance hormones presents for care, the provider should assess the patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated. The patient should continue to be monitored by physical examinations and laboratory testing on a regular basis, as outlined in the literature (Feldman & Safer, 2009; Hembree et al., 2009). The dose and form of hormones should be revisited regularly with any changes in the patient's health status and available evidence on the potential long-term risks of hormones (See *Hormone Regimens,* below).

4. Initiating hormonal feminization/masculinization

This clinical situation requires the greatest commitment in terms of provider time and expertise. Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Although a wide variety of hormone regimens have been published (Dahl et al., 2006; Hembree et al., 2009; Moore et al., 2003), there are no published reports of randomized clinical trials comparing safety and efficacy. Despite this variation, a reasonable framework for initial risk assessment and ongoing monitoring of hormone therapy can be constructed, based on the efficacy and safety evidence presented above.

Risk Assessment and Modification for Initiating Hormone Therapy

The initial evaluation for hormone therapy assesses a patient's clinical goals and risk factors for hormone-related adverse events. During the risk assessment, the patient and clinician should develop a plan for reducing risks wherever possible, either prior to initiating therapy or as part of ongoing harm reduction.

All assessments should include a thorough physical exam, including weight, height, and blood pressure. The need for breast, genital, and rectal exams, which are sensitive issues for most transsexual, transgender, and gender nonconforming patients, should be based on individual risks and preventive health care needs (Feldman & Goldberg, 2006; Feldman, 2007).

Preventive care

Hormone providers should address preventive health care with patients, particularly if a patient does not have a primary care provider. Depending on a patient's age and risk profile, there may be appropriate screening tests or exams for conditions affected by hormone therapy. Ideally, these screening tests should be carried out prior to the start of hormone therapy.

Risk assessment and modification for feminizing hormone therapy (MtF)

There are no absolute contraindications to feminizing therapy *per se*, but absolute contraindications exist for the different feminizing agents, particularly estrogen. These include previous venous thrombotic events related to an underlying hypercoagulable condition, history of estrogen-sensitive neoplasm, and end-stage chronic liver disease (Gharib et al., 2005).

Other medical conditions, as noted in Table 2 and Appendix B, can be exacerbated by estrogen or androgen blockade, and therefore should be evaluated and reasonably well controlled prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Clinicians should particularly attend to tobacco use, as it is associated with increased risk of venous thrombosis, which is further increased with estrogen use. Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of feminizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Risk assessment and modification for masculinizing hormone therapy (FtM)

Absolute contraindications to testosterone therapy include pregnancy, unstable coronary artery disease, and untreated polycythemia with a hematocrit of 55% or higher (Carnegie, 2004). Because the aromatization of testosterone to estrogen may increase risk in patients with a history of breast or other estrogen dependent cancers (Moore et al., 2003), consultation with an oncologist may be indicated prior to hormone use. Co-morbid conditions likely to be exacerbated by testosterone use should be evaluated and treated, ideally prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

An increased prevalence of polycystic ovarian syndrome (PCOS) has been noted among FtM patients even in the absence of testosterone use (Baba et al., 2007; Balen, Schachter, Montgomery, Reid, & Jacobs, 1993; Bosinski et al., 1997). While there is no evidence that PCOS is related to the development of a transsexual, transgender, or gender nonconforming identity, PCOS is associated with increased risk of diabetes, cardiac disease, high blood pressure, and ovarian and endometrial cancers (Cattrall & Healy, 2004). Signs and symptoms of PCOS should be evaluated prior to initiating testosterone therapy, as testosterone may affect many of these conditions. Testosterone can affect the developing fetus (Physicians' Desk Reference, 2011), and patients at risk of becoming pregnant require highly effective birth control.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of masculinizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Clinical Monitoring during Hormone Therapy for Efficacy and Adverse Events

The purpose of clinical monitoring during hormone use is to assess the degree of feminization/masculinization and the possible presence of adverse effects of medication. However, as with the monitoring of any long-term medication, monitoring should take place in the context of comprehensive health care. Suggested clinical monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009). Patients with co-morbid medical conditions may need to be monitored more frequently. Healthy patients in geographically remote or resource-poor areas may be able to use alternative strategies, such as telehealth, or cooperation with local providers such as nurses and physician assistants. In the absence of other indications, health professionals may prioritize monitoring for those risks that are either likely to be increased by hormone therapy or possibly increased by hormone therapy but clinically serious in nature.

Efficacy and risk monitoring during feminizing hormone therapy (MtF)

The best assessment of hormone efficacy is clinical response: Is a patient developing a feminized body while minimizing masculine characteristics, consistent with that patient's gender goals? In order to more rapidly predict the hormone dosages that will achieve clinical response, one can measure testosterone levels for suppression below the upper limit of the normal female range, and estradiol levels within a premenopausal female range but well below supraphysiologic levels (Feldman & Safer, 2009; Hembree et al., 2009).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs of cardiovascular impairment and venous thromboembolism (VTE) through measurement of blood pressure, weight, and pulse; heart and lung exams; and examination of the extremities for peripheral edema, localized swelling, or pain (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual co-morbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Efficacy and risk monitoring during masculinizing hormone therapy (FtM)

The best assessment of hormone efficacy is clinical response: Is a patient developing a masculinized body while minimizing feminine characteristics, consistent with that patient's gender goals? Clinicians can achieve a good clinical response with the least likelihood of adverse events by maintaining testosterone levels within the normal male range while avoiding supraphysiological

levels (Dahl et al., 2006; Hembree et al., 2009). For patients using intramuscular (IM) testosterone cypionate or enanthate, some clinicians check trough levels while others prefer midcycle levels (Dahl et al., 2006; Hembree et al., 2009; Tangpricha, Turner, Malabanan, & Holick, 2001; Tangpricha, Ducharme, Barber, & Chipkin, 2003).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs and symptoms of excessive weight gain, acne, uterine break-through bleeding, and cardiovascular impairment, as well as psychiatric symptoms in at-risk patients. Physical examinations should include measurement of pressure, weight, pulse, and skin; and heart and lung exams (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual co-morbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Hormone Regimens

To date, no controlled clinical trials of any feminizing/masculinizing hormone regimen have been conducted to evaluate safety or efficacy in producing physical transition. As a result, wide variation in doses and types of hormones have been published in the medical literature (Moore et al., 2003; Tangpricha et al., 2003; van Kesteren, Asscheman, Megens, & Gooren, 1997). In addition, access to particular medications may be limited by a patient's geographical location and/or social or econonomic situations. For these reasons, WPATH does not describe or endorse a particular feminizing/masculinizing hormone regimen. Rather, the medication classes and routes of administration used in most published regimens are broadly reviewed.

As outlined above, there are demonstrated safety differences in individual elements of various regimens. The Endocrine Society Guidelines (Hembree et al., 2009) and Feldman and Safer (2009) provide specific guidance regarding the types of hormones and suggested dosing to maintain levels within physiologic ranges for a patient's desired gender expression (based on goals of full feminization/masculinization). It is strongly recommend that hormone providers regularly review the literature for new information and use those medications that safely meet individual patient needs with available local resources.

Regimens for feminizing hormone therapy (MtF)

Estrogen

Use of oral estrogen, and specifically ethinyl estradiol, appears to increase the risk of VTE. Because of this safety concern, ethinyl estradiol is not recommended for feminizing hormone therapy. Transdermal estrogen is recommended for those patients with risks factors for VTE. The risk of adverse events increases with higher doses, particular those resulting in supraphysiologic levels (Hembree et al., 2009). Patients with co-morbid conditions that can be affected by estrogen should avoid oral estrogen if possible and be started at lower levels. Some patients may not be able to safely use the levels of estrogen needed to get the desired results. This possibility needs to be discussed with patients well in advance of starting hormone therapy.

Androgen reducing medications ("anti-androgens")

A combination of estrogen and "anti-androgens" is the most commonly studied regimen for feminization. Androgen reducing medications, from a variety of classes of drugs, have the effect of reducing either endogenous testosterone levels or testosterone activity, and thus diminishing masculine characteristics such as body hair. They minimize the dosage of estrogen needed to suppress testosterone, thereby reducing the risks associated with high-dose exogenous estrogen (Prior, Vigna, Watson, Diewold, & Robinow, 1986; Prior, Vigna, & Watson, 1989).

Common anti-androgens include the following:

- Spironolactone, an antihypertensive agent, directly inhibits testosterone secretion and androgen binding to the androgen receptor. Blood pressure and electrolytes need to be monitored because of the potential for hyperkalemia.

- Cyproterone acetate is a progestational compound with anti-androgenic properties. This medication is not approved in the United States because of concerns over potential hepatotoxicity, but it is widely used elsewhere (De Cuypere et al., 2005).

- GnRH agonists (e.g., goserelin, buserelin, triptorelin) are neurohormones that block the gonadtropin releasing hormone receptor, thus blocking the release of follicle stimulating hormone and luteinizing hormone. This leads to highly effective gonadal blockade. However, these medications are expensive and only available as injectables or implants.

- 5-alpha reductase inhibitors (finasteride and dutasteride) block the conversion of testosterone to the more active agent, 5-alpha-dihydrotestosterone. These medications have beneficial effects on scalp hair loss, body hair growth, sebaceous glands, and skin consistency.

Cyproterone and spironolactone are the most commonly used anti-androgens and are likely the most cost-effective.

Progestins

With the exception of cyproterone, the inclusion of progestins in feminizing hormone therapy is controversial (Oriel, 2000). Because progestins play a role in mammary development on a cellular level, some clinicians believe that these agents are necessary for full breast development (Basson & Prior, 1998; Oriel, 2000). However, a clinical comparison of feminization regimens with and without progestins found that the addition of progestins neither enhanced breast growth nor lowered serum levels of free testosterone (Meyer III et al., 1986). There are concerns regarding potential adverse effects of progestins, including depression, weight gain, and lipid changes (Meyer III et al., 1986; Tangpricha et al., 2003). Progestins (especially medroxyprogesterone) are also suspected to increase breast cancer risk and cardiovascular risk in women (Rossouw et al., 2002). Micronized progesterone may be better tolerated and have a more favorable impact on the lipid profile than medroxyprogesterone does (de Lignières, 1999; Fitzpatrick, Pace, & Wiita, 2000).

Regimens for masculinizing hormone therapy (FtM)

Testosterone

Testosterone generally can be given orally, transdermally, or parenterally (IM), although buccal and implantable preparations are also available. Oral testosterone undecenoate, available outside the United States, results in lower serum testosterone levels than non-oral preparations and has limited efficacy in suppressing menses (Feldman, 2005, April; Moore et al., 2003). Because intramuscular testosterone cypionate or enanthate are often administered every 2-4 weeks, some patients may notice cyclic variation in effects (e.g., fatigue and irritability at the end of the injection cycle, aggression or expansive mood at the beginning of the injection cycle), as well as more time outside the normal physiologic levels (Jockenhövel, 2004). This may be mitigated by using a lower but more frequent dosage schedule or by using a daily transdermal preparation (Dobs et al., 1999; Jockenhövel, 2004; Nieschlag et al., 2004). Intramuscular testosterone undecenoate (not currently available in the United States) maintains stable, physiologic testosterone levels over approximately 12 weeks and has been effective in both the setting of hypogonadism and in FtM individuals (Mueller, Kiesewetter, Binder, Beckmann, & Dittrich, 2007; Zitzmann, Saad, & Nieschlag, 2006). There is evidence that transdermal and intramuscular testosterone achieve similar masculinizing results, although the timeframe may be somewhat slower with transdermal preparations (Feldman, 2005, April). Especially as patients age, the goal is to use the lowest dose needed to maintain the desired clinical result, with appropriate precautions being made to maintain bone density.

Other agents

Progestins, most commonly medroxyprogesterone, can be used for a short period of time to assist with menstrual cessation early in hormone therapy. GnRH agonists can be used similarly, as well as for refractory uterine bleeding in patients without an underlying gynecological abnormality.

Bioidentical and compounded hormones

As discussion surrounding the use of bioidentical hormones in postmenopausal hormone replacement has heightened, interest has also increased in the use of similar compounds in feminizing/masculinizing hormone therapy. There is no evidence that custom compounded bioidentical hormones are safer or more effective than government agency-approved bioidentical hormones (Sood, Shuster, Smith, Vincent, & Jatoi, 2011). Therefore, it has been advised by the North American Menopause Society (2010) and others to assume that, whether the hormone is from a compounding pharmacy or not, if the active ingredients are similar, it should have a similar side-effect profile. WPATH concurs with this assessment.

IX
Reproductive Health

Many transgender, transsexual, and gender nonconforming people will want to have children. Because feminizing/masculinizing hormone therapy limits fertility (Darney, 2008; Zhang, Gu, Wang, Cui, & Bremner, 1999), it is desirable for patients to make decisions concerning fertility before starting hormone therapy or undergoing surgery to remove/alter their reproductive organs. Cases are known of people who received hormone therapy and genital surgery and later regretted their inability to parent genetically related children (De Sutter, Kira, Verschoor, & Hotimsky, 2002).

Health care professionals – including mental health professionals recommending hormone therapy or surgery, hormone-prescribing physicians, and surgeons – should discuss reproductive options with patients prior to initiation of these medical treatments for gender dysphoria. These discussions should occur even if patients are not interested in these issues at the time of treatment, which may be more common for younger patients (De Sutter, 2009). Early discussions are desirable, but not always possible. If an individual has not had complete sex reassignment surgery, it may be possible to stop hormones long enough for natal hormones to recover, allowing the production of mature

gametes (Payer, Meyer III, & Walker, 1979; Van den Broecke, Van der Elst, Liu, Hovatta, & Dhont, 2001).

Besides debate and opinion papers, very few research papers have been published on the reproductive health issues of individuals receiving different medical treatments for gender dysphoria. Another group who faces the need to preserve reproductive function in light of loss or damage to their gonads are people with malignances that require removal of reproductive organs or use of damaging radiation or chemotherapy. Lessons learned from that group can be applied to people treated for gender dysphoria.

MtF patients, especially those who have not already reproduced, should be informed about sperm preservation options and encouraged to consider banking their sperm prior to hormone therapy. In a study examining testes that were exposed to high-dose estrogen (Payer et al., 1979), findings suggest that stopping estrogen may allow the testes to recover. In an article reporting on the opinions of MtF individuals towards sperm freezing (De Sutter et al., 2002), the vast majority of 121 survey respondents felt that the availability of freezing sperm should be discussed and offered by the medical world. Sperm should be collected before hormone therapy or after stopping the therapy until the sperm count rises again. Cryopreservation should be discussed even if there is poor semen quality. In adults with azoospermia, a testicular biopsy with subsequent cryopreservation of biopsied material for sperm is possible, but may not be successful.

Reproductive options for FtM patients might include oocyte (egg) or embryo freezing. The frozen gametes and embryo could later be used with a surrogate woman to carry to pregnancy. Studies of women with polycystic ovarian disease suggest that the ovary can recover in part from the effects of high testosterone levels (Hunter & Sterrett, 2000). Stopping the testosterone briefly might allow for ovaries to recover enough to make eggs; success likely depends on the patient's age and duration of testosterone treatment. While not systematically studied, some FtM individuals are doing exactly that, and some have been able to become pregnant and deliver children (More, 1998).

Patients should be advised that these techniques are not available everywhere and can be very costly. Transsexual, transgender, and gender nonconforming people should not be refused reproductive options for any reason.

A special group of individuals are prepubertal or pubertal adolescents who will never develop reproductive function in their natal sex due to blockers or cross gender hormones. At this time there is no technique for preserving function from the gonads of these individuals.

X

Voice and Communication Therapy

Communication, both verbal and nonverbal, is an important aspect of human behavior and gender expression. Transsexual, transgender, and gender nonconforming people might seek the assistance of a voice and communication specialist to develop vocal characteristics (e.g., pitch, intonation, resonance, speech rate, phrasing patterns) and non-verbal communication patterns (e.g., gestures, posture/movement, facial expressions) that facilitate comfort with their gender identity. Voice and communication therapy may help to alleviate gender dysphoria and be a positive and motivating step towards achieving one's goals for gender role expression.

Competency of Voice and Communication Specialists Working with Transsexual, Transgender, and Gender Nonconforming Clients

Specialists may include speech-language pathologists, speech therapists, and speech-voice clinicians. In most countries the professional association for speech-language pathologists requires specific qualifications and credentials for membership. In some countries the government regulates practice through licensing, certification, or registration processes (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia; Vancouver Coastal Health, Vancouver, British Columbia, Canada).

The following are recommended minimum credentials for voice and communication specialists working with transsexual, transgender, and gender nonconforming clients:

1. Specialized training and competence in the assessment and development of communication skills in transsexual, transgender, and gender nonconforming clients.

2. A basic understanding of transgender health, including hormonal and surgical treatments for feminization/masculinization and trans-specific psychosocial issues as outlined in the *SOC*; and familiarity with basic sensitivity protocols such as the use of preferred gender pronoun and name (Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

3. Continuing education in the assessment and development of communication skills in transsexual, transgender, and gender nonconforming clients. This may include attendance at professional meetings, workshops, or seminars; participation in research related to gender identity issues; independent study; or mentoring from an experienced, certified clinician.

Other professionals such as vocal coaches, theatre professionals, singing teachers, and movement experts may play a valuable adjunct role. Such professionals will ideally have experience working with, or be actively collaborating with, speech-language pathologists.

Assessment and Treatment Considerations

The overall purpose of voice and communication therapy is to help clients adapt their voice and communication in a way that is both safe and authentic, resulting in communication patterns that clients feel are congruent with their gender identity and that reflect their sense of self (Adler, Hirsch, & Mordaunt, 2006). It is essential that voice and communication specialists be sensitive to individual communication preferences. Communication – style, voice, choice of language, etc. – is personal. Individuals should not be counseled to adopt behaviors with which they are not comfortable or which do not feel authentic. Specialists can best serve their clients by taking the time to understand a person's gender concerns and goals for gender role expression (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

Individuals may choose the communication behaviors that they wish to acquire in accordance with their gender identity. These decisions are also informed and supported by the knowledge of the voice and communication specialist and by the assessment data for a specific client (Hancock, Krissinger, & Owen, 2010). Assessment includes a client's self-evaluation and a specialist's evaluation of voice, resonance, articulation, spoken language, and non-verbal communication (Adler et al., 2006; Hancock et al., 2010).

Voice and communication treatment plans are developed by considering the available research evidence, the clinical knowledge and experience of the specialist, and the client's own goals and values (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia; Vancouver Coastal Health, Vancouver, British Columbia, Canada). Targets of treatment typically include pitch, intonation, loudness and stress patterns, voice quality, resonance, articulation, speech rate and phrasing, language, and non-verbal communication (Adler et al., 2006; Davies & Goldberg, 2006; de Bruin, Coerts, & Greven, 2000; Gelfer, 1999; McNeill, 2006; Oates & Dacakis, 1983). Treatment may involve individual and/or group sessions. The frequency and duration of treatment will vary according to a client's needs. Existing protocols for voice and

communication treatment can be considered in developing an individualized therapy plan (Carew, Dacakis, & Oates, 2007; Dacakis, 2000; Davies & Goldberg, 2006; Gelfer, 1999; McNeill, Wilson, Clark, & Deakin, 2008; Mount & Salmon, 1988).

Feminizing or masculinizing the voice involves non-habitual use of the voice production mechanism. Prevention measures are necessary to avoid the possibility of vocal misuse and long-term vocal damage. All voice and communication therapy services should therefore include a vocal health component (Adler et al., 2006).

Vocal Health Considerations after Voice Feminization Surgery

As noted in section XI, some transsexual, transgender, and gender nonconforming people will undergo voice feminization surgery. (Voice deepening can be achieved through masculinizing hormone therapy, but feminizing hormones do not have an impact on the adult MtF voice.) There are varying degrees of satisfaction, safety, and long-term improvement in patients who have had such surgery. It is recommended that individuals undergoing voice feminization surgery also consult a voice and communication specialist to maximize the surgical outcome, help protect vocal health, and learn non-pitch related aspects of communication. Voice surgery procedures should include follow-up sessions with a voice and communication specialist who is licensed and/or credentialed by the board responsible for speech therapists/speech-language pathologists in that country (Kanagalingam et al., 2005; Neumann & Welzel, 2004).

XI

Surgery_

Sex Reassignment Surgery Is Effective and Medically Necessary

Surgery – particularly genital surgery – is often the last and the most considered step in the treatment process for gender dysphoria. While many transsexual, transgender, and gender nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria (Hage

& Karim, 2000). For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity. Moreover, surgery can help patients feel more at ease in the presence of sex partners or in venues such as physicians' offices, swimming pools, or health clubs. In some settings, surgery might reduce risk of harm in the event of arrest or search by police or other authorities.

Follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Gijs & Brewaeys, 2007; Klein & Gorzalka, 2009; Pfäfflin & Junge, 1998). Additional information on the outcomes of surgical treatments are summarized in Appendix D.

Ethical Questions Regarding Sex Reassignment Surgery

In ordinary surgical practice, pathological tissues are removed to restore disturbed functions, or alterations are made to body features to improve a patient's self image. Some people, including some health professionals, object on ethical grounds to surgery as a treatment for gender dysphoria, because these conditions are thought not to apply.

It is important that health professionals caring for patients with gender dysphoria feel comfortable about altering anatomically normal structures. In order to understand how surgery can alleviate the psychological discomfort and distress of individuals with gender dysphoria, professionals need to listen to these patients discuss their symptoms, dilemmas, and life histories. The resistance against performing surgery on the ethical basis of "above all do no harm" should be respected, discussed, and met with the opportunity to learn from patients themselves about the psychological distress of having gender dysphoria and the potential for harm caused by denying access to appropriate treatments.

Genital and breast/chest surgical treatments for gender dysphoria are not merely another set of elective procedures. Typical elective procedures involve only a private mutually consenting contract between a patient and a surgeon. Genital and breast/chest surgeries as medically necessary treatments for gender dysphoria are to be undertaken only after assessment of the patient by qualified mental health professionals, as outlined in section VII of the *SOC*. These surgeries may be performed once there is written documentation that this assessment has occurred and that the person has met the criteria for a specific surgical treatment. By following this procedure, mental health professionals, surgeons, and of course patients, share responsibility for the decision to make irreversible changes to the body.

It is unethical to deny availability or eligibility for sex reassignment surgeries solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis C or B.

Relationship of Surgeons with Mental Health Professionals, Hormone-Prescribing Physicians (if Applicable), and Patients (Informed Consent)

The role of a surgeon in the treatment of gender dysphoria is not that of a mere technician. Rather, conscientious surgeons will have insight into each patient's history and the rationale that led to the referral for surgery. To that end, surgeons must talk at length with their patients and have close working relationships with other health professionals who have been actively involved in their clinical care.

Consultation is readily accomplished when a surgeon practices as part of an interdisciplinary health care team. In the absence of this, a surgeon must be confident that the referring mental health professional(s), and if applicable the physician who prescribes hormones, are competent in the assessment and treatment of gender dysphoria, because the surgeon is relying heavily on their expertise.

Once a surgeon is satisfied that the criteria for specific surgeries have been met (as outlined below), surgical treatment should be considered and a preoperative surgical consultation should take place. During this consultation, the procedure and postoperative course should be extensively discussed with the patient. Surgeons are responsible for discussing all of the following with patients seeking surgical treatments for gender dysphoria:

- The different surgical techniques available (with referral to colleagues who provide alternative options);
- The advantages and disadvantages of each technique;
- The limitations of a procedure to achieve "ideal" results; surgeons should provide a full range of before-and-after photographs of their own patients, including both successful and unsuccessful outcomes;
- The inherent risks and possible complications of the various techniques; surgeons should inform patients of their own complication rates with each procedure.

These discussions are the core of the informed consent process, which is both an ethical and legal requirement for any surgical procedure. Ensuring that patients have a realistic expectation of outcomes is important in achieving a result that will alleviate their gender dysphoria.

All of this information should be provided to patients in writing, in a language in which they are fluent, and in graphic illustrations. Patients should receive the information in advance (possibly via the internet) and given ample time to review it carefully. The elements of informed consent should always be discussed face-to-face prior to the surgical intervention. Questions can then be answered and written informed consent can be provided by the patient. Because these surgeries are irreversibile, care should be taken to ensure that patients have sufficient time to absorb information fully before they are asked to provide informed consent. A minimum of 24 hours is suggested.

Surgeons should provide immediate aftercare and consultation with other physicians serving the patient in the future. Patients should work with their surgeon to develop an adequate aftercare plan for the surgery.

Overview of Surgical Procedures for the Treatment of Patients with Gender Dysphoria

For the male-to-female (MtF) patient, surgical procedures may include the following:

1. Breast/chest surgery: augmentation mammoplasty (implants/lipofilling);

2. Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty;

3. Non-genital, non-breast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, and various aesthetic procedures.

For the female-to-male (FtM) patient, surgical procedures may include the following:

1. Breast/chest surgery: subcutaneous mastectomy, creation of a male chest;

2. Genital surgery: hysterectomy/ovariectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses;

3. Non-genital, non-breast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures.

Reconstructive Versus Aesthetic Surgery

The question of whether sex reassignment surgery should be considered "aesthetic" surgery or "reconstructive" surgery is pertinent not only from a philosophical point of view, but also from a financial point of view. Aesthetic or cosmetic surgery is mostly regarded as not medically necessary and therefore is typically paid for entirely by the patient. In contrast, reconstructive procedures are considered medically necessary – with unquestionable therapeutic results – and thus paid for partially or entirely by national health systems or insurance companies.

Unfortunately, in the field of plastic and reconstructive surgery (both in general and specifically for gender-related surgeries), there is no clear distinction between what is purely reconstructive and what is purely cosmetic. Most plastic surgery procedures actually are a mixture of both reconstructive and cosmetic components.

While most professionals agree that genital surgery and mastectomy cannot be considered purely cosmetic, opinions diverge as to what degree other surgical procedures (e.g., breast augmentation, facial feminization surgery) can be considered purely reconstructive. Although it may be much easier to see a phalloplasty or a vaginoplasty as an intervention to end lifelong suffering, for certain patients an intervention like a reduction rhinoplasty can have a radical and permanent effect on their quality of life, and therefore is much more medically necessary than for somebody without gender dysphoria.

Criteria for Surgeries

As for all of the *SOC*, the criteria for initiation of surgical treatments for gender dysphoria were developed to promote optimal patient care. While the *SOC* allow for an individualized approach to best meet a patient's health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional. For some surgeries, additional criteria include preparation and treatment consisting of feminizing/masculinizing hormone therapy and one year of continuous living in a gender role that is congruent with one's gender identity.

These criteria are outlined below. Based on the available evidence and expert clinical consensus, different recommendations are made for different surgeries.

The *SOC* do not specify an order in which different surgeries should occur. The number and sequence of surgical procedures may vary from patient to patient, according to their clinical needs.

Criteria for breast/chest surgery (one referral)

Criteria for mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a pre-requisite.

Criteria for breast augmentation (implants/lipofilling) in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for genital surgery (two referrals)

The criteria for genital surgery are specific to the type of surgery being requested.

Criteria for hysterectomy and ovariectomy in FtM patients and for orchiectomy in MtF patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled.
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before the patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these procedures for medical indications other than gender dysphoria.

Criteria for metoidioplasty or phalloplasty in FtM patients and for vaginoplasty in MtF patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).
6. 12 continuous months of living in a gender role that is congruent with their gender identity;

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

Rationale for a preoperative, 12-month experience of living in an identity-congruent gender role:

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery. As noted in section VII, the social aspects of changing one's gender role are usually challenging – often more so than the physical aspects. Changing gender role can have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role. Support from a qualified mental health professional and from peers can be invaluable in ensuring a successful gender role adaptation (Bockting, 2008).

The duration of 12 months allows for a range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences). During this time, patients should present consistently, on a day-to-day basis and across all settings of life, in their desired gender role. This includes coming out to partners, family, friends, and community members (e.g., at school, work, other settings).

Health professionals should clearly document a patient's experience in the gender role in the medical chart, including the start date of living full time for those who are preparing for genital surgery. In some situations, if needed, health professionals may request verification that this criterion has been fulfilled: They may communicate with individuals who have related to the patient in an identity-congruent gender role, or request documentation of a legal name and/or gender marker change, if applicable.

Surgery for Persons with Psychotic Conditions and Other Serious Mental Illnesses

When patients with gender dysphoria are also diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated. Reevaluation by a mental health professional qualified to assess and manage psychotic conditions should be

conducted prior to surgery, describing the patient's mental status and readiness for surgery. It is preferable that this mental health professional be familiar with the patient. No surgery should be performed while a patient is actively psychotic (De Cuypere & Vercruysse, 2009).

Competency of Surgeons Performing Breast/Chest or Genital Surgery

Physicians who perform surgical treatments for gender dsyphoria should be urologists, gynecologists, plastic surgeons, or general surgeons, and board-certified as such by the relevant national and/or regional association. Surgeons should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. Even experienced surgeons must be willing to have their surgical skills reviewed by their peers. An official audit of surgical outcomes and publication of these results would be greatly reassuring to both referring health professionals and patients. Surgeons should regularly attend professional meetings where new techniques are presented. The internet is often effectively used by patients to share information on their experience with surgeons and their teams.

Ideally, surgeons should be knowledgeable about more than one surgical technique for genital reconstruction so that they, in consultation with patients, can choose the ideal technique for each individual. Alternatively, if a surgeon is skilled in a single technique and this procedure is either not suitable for or desired by a patient, the surgeon should inform the patient about other procedures and offer referral to another appropriately skilled surgeon.

Breast/Chest Surgery Techniques and Complications

Although breast/chest appearance is an important secondary sex characteristic, breast presence or size is not involved in the legal definitions of sex and gender and is not necessary for reproduction. The performance of breast/chest operations for treatment of gender dysphoria should be considered with the same care as beginning hormone therapy, as both produce relatively irreversible changes to the body.

For the MtF patient, a breast augmentation (sometimes called "chest reconstruction") is not different from the procedure in a natal female patient. It is usually performed through implantation of breast prostheses and occasionally with the lipofilling technique. Infections and capsular fibrosis are rare complications of augmentation mammoplasty in MtF patients (Kanhai, Hage, Karim, & Mulder, 1999).

For the FtM patient, a mastectomy or "male chest contouring" procedure is available. For many FtM patients, this is the only surgery undertaken. When the amount of breast tissue removed requires skin removal, a scar will result and the patient should be so informed. Complications of subcutaneous mastectomy can include nipple necrosis, contour irregularities, and unsightly scarring (Monstrey et al., 2008).

Genital Surgery Techniques and Complications

Genital surgical procedures for the MtF patient may include orchiectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty. Techniques include penile skin inversion, pedicled colosigmoid transplant, and free skin grafts to line the neovagina. Sexual sensation is an important objective in vaginoplasty, along with creation of a functional vagina and acceptable cosmesis.

Surgical complications of MtF genital surgery may include complete or partial necrosis of the vagina and labia, fistulas from the bladder or bowel into the vagina, stenosis of the urethra, and vaginas that are either too short or too small for coitus. While the surgical techniques for creating a neovagina are functionally and aesthetically excellent, anorgasmia following the procedure has been reported, and a second stage labiaplasty may be needed for cosmesis (Klein & Gorzalka, 2009; Lawrence, 2006).

Genital surgical procedures for FtM patients may include hysterectomy, ovariectomy (salpingo-oophorectomy), vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, and phalloplasty. For patients without former abdominal surgery, the laparoscopic technique for hysterectomy and salpingo-oophorectomy is recommended to avoid a lower-abdominal scar. Vaginal access may be difficult as most patients are nulliparous and have often not experienced penetrative intercourse. Current operative techniques for phalloplasty are varied. The choice of techniques may be restricted by anatomical or surgical considerations and by a client's financial considerations. If the objectives of phalloplasty are a neophallus of good appearance, standing micturition, sexual sensation, and/or coital ability, patients should be clearly informed that there are several separate stages of surgery and frequent technical difficulties, which may require additional operations. Even metoidioplasty, which in theory is a one-stage procedure for construction of a microphallus, often requires more than one operation. The objective of standing micturition with this technique can not always be ensured (Monstrey et al., 2009).

Complications of phalloplasty in FtMs may include frequent urinary tract stenoses and fistulas, and occasionally necrosis of the neophallus. Metoidioplasty results in a micropenis, without the capacity for standing urination. Phalloplasty, using a pedicled or a free vascularized flap, is a lengthy, multi-stage procedure with significant morbidity that includes frequent urinary complications and

unavoidable donor site scarring. For this reason, many FtM patients never undergo genital surgery other than hysterectomy and salpingo-oophorectomy (Hage & De Graaf, 1993).

Even patients who develop severe surgical complications seldom regret having undergone surgery. The importance of surgery can be appreciated by the repeated finding that quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2006).

Other Surgeries

Other surgeries for assisting in body feminization include reduction thyroid chondroplasty (reduction of the Adam's apple), voice modification surgery, suction-assisted lipoplasty (contour modeling) of the waist, rhinoplasty (nose correction), facial bone reduction, face-lift, and blepharoplasty (rejuvenation of the eyelid). Other surgeries for assisting in body masculinization include liposuction, lipofilling, and pectoral implants. Voice surgery to obtain a deeper voice is rare but may be recommended in some cases, such as when hormone therapy has been ineffective.

Although these surgeries do not require referral by mental health professionals, such professionals can play an important role in assisting clients in making a fully informed decision about the timing and implications of such procedures in the context of the social transition.

Although most of these procedures are generally labeled "purely aesthetic," these same operations in an individual with severe gender dysphoria can be considered medically necessary, depending on the unique clinical situation of a given patient's condition and life situation. This ambiguity reflects reality in clinical situations, and allows for individual decisions as to the need and desirability of these procedures.

XII

Postoperative Care and Follow-up

Long-term postoperative care and follow-up after surgical treatments for gender dysphoria are associated with good surgical and psychosocial outcomes (Monstrey et al., 2009). Follow-up is important to a patient's subsequent physical and mental health and to a surgeon's knowledge about the benefits and limitations of surgery. Surgeons who operate on patients coming from long

distances should include personal follow-up in their care plan and attempt to ensure affordable local long-term aftercare in their patients' geographic region.

Postoperative patients may sometimes exclude themselves from follow-up by specialty providers, including the hormone-prescribing physician (for patients receiving hormones), not recognizing that these providers are often best able to prevent, diagnose, and treat medical conditions that are unique to hormonally and surgically treated patients. The need for follow-up equally extends to mental health professionals, who may have spent a longer period of time with the patient than any other professional and therefore are in an excellent position to assist in any postoperative adjustment difficulties. Health professionals should stress the importance of postoperative follow-up care with their patients and offer continuity of care.

Postoperative patients should undergo regular medical screening according to recommended guidelines for their age. This is discussed more in the next section.

XIII

Lifelong Preventive and Primary Care

Transsexual, transgender, and gender nonconforming people need health care throughout their lives. For example, to avoid the negative secondary effects of having a gonadectomy at a relatively young age and/or receiving long-term, high-dose hormone therapy, patients need thorough medical care by providers experienced in primary care and transgender health. If one provider is not able to provide all services, ongoing communication among providers is essential.

Primary care and health maintenance issues should be addressed before, during, and after any possible changes in gender role and medical interventions to alleviate gender dysphoria. While hormone providers and surgeons play important roles in preventive care, every transsexual, transgender, and gender nonconforming person should partner with a primary care provider for overall health care needs (Feldman, 2007).

General Preventive Health Care

Screening guidelines developed for the general population are appropriate for organ systems that are unlikely to be affected by feminizing/masculinizing hormone therapy. However, in areas such

as cardiovascular risk factors, osteoporosis, and some cancers (breast, cervical, ovarian, uterine, and prostate), such general guidelines may either over- or underestimate the cost-effectiveness of screening individuals who are receiving hormone therapy.

Several resources provide detailed protocols for the primary care of patients undergoing feminizing/masculinizing hormone therapy, including therapy that is provided after sex reassignment surgeries (Center of Excellence for Transgender Health, UCSF, 2011; Feldman & Goldberg, 2006; Feldman, 2007; Gorton, Buth, & Spade, 2005). Clinicians should consult their national evidence-based guidelines and discuss screening with their patients in light of the effects of hormone therapy on their baseline risk.

Cancer Screening

Cancer screening of organ systems that are associated with sex can present particular medical and psychosocial challenges for transsexual, transgender, and gender nonconforming patients and their health care providers. In the absence of large-scale prospective studies, providers are unlikely to have enough evidence to determine the appropriate type and frequency of cancer screenings for this population. Over-screening results in higher health care costs, high false positive rates, and often unnecessary exposure to radiation and/or diagnostic interventions such as biopsies. Under-screening results in diagnostic delay for potentially treatable cancers. Patients may find cancer screening gender affirming (such as mammograms for MtF patients) or both physically and emotionally painful (such as Pap smears offer continuity of care for FtM patients).

Urogenital Care

Gynecologic care may be necessary for transsexual, transgender, and gender nonconforming people of both sexes. For FtM patients, such care is needed predominantly for individuals who have not had genital surgery. For MtF patients, such care is needed after genital surgery. While many surgeons counsel patients regarding postoperative urogenital care, primary care clinicians and gynecologists should also be familiar with the special genital concerns of this population.

All MtF patients should receive counseling regarding genital hygiene, sexuality, and prevention of sexually transmitted infections; those who have had genital surgery should also be counseled on the need for regular vaginal dilation or penetrative intercourse in order to maintain vaginal depth and width (van Trotsenburg, 2009). Due to the anatomy of the male pelvis, the axis and the dimensions

of the neovagina differ substantially from those of a biologic vagina. This anatomic difference can affect intercourse if not understood by MtF patients and their partners (van Trotsenburg, 2009).

Lower urinary tract infections occur frequently in MtF patients who have had surgery because of the reconstructive requirements of the shortened urethra. In addition, these patients may suffer from functional disorders of the lower urinary tract; such disorders may be caused by damage of the autonomous nerve supply of the bladder floor during dissection between the rectum and the bladder, and by a change of the position of the bladder itself. A dysfunctional bladder (e.g., overactive bladder, stress or urge urinary incontinence) may occur after sex reassignment surgery (Hoebeke et al., 2005; Kuhn, Hiltebrand, & Birkhauser, 2007).

Most FtM patients do not undergo vaginectomy (colpectomy). For patients who take masculinizing hormones, despite considerable conversion of testosterone to estrogens, atrophic changes of the vaginal lining can be observed regularly and may lead to pruritus or burning. Examination can be both physically and emotionally painful, but lack of treatment can seriously aggravate the situation. Gynecologists treating the genital complaints of FtM patients should be aware of the sensitivity that patients with a male gender identity and masculine gender expression might have around having genitals typically associated with the female sex.

XIV

Applicability of the Standards of Care to People Living in Institutional Environments

The *SOC* in their entirety apply to all transsexual, transgender, and gender nonconforming people, irrespective of their housing situation. People should not be discriminated against in their access to appropriate health care based on where they live, including institutional environments such as prisons or long-/intermediate-term health care facilities (Brown, 2009). Health care for transsexual, transgender, and gender nonconforming people living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting within the same community.

All elements of assessment and treatment as described in the *SOC* can be provided to people living in institutions (Brown, 2009). Access to these medically necessary treatments should not be denied on the basis of institutionalization or housing arrangements. If the in-house expertise of health professionals in the direct or indirect employ of the institution does not exist to assess

and/or treat people with gender dysphoria, it is appropriate to obtain outside consultation from professionals who are knowledgeable about this specialized area of health care.

People with gender dysphoria in institutions may also have co-existing mental health conditions (Cole et al., 1997). These conditions should be evaluated and treated appropriately.

People who enter an institution on an appropriate regimen of hormone therapy should be continued on the same, or similar, therapies and monitored according to the *SOC*. A "freeze frame" approach is not considered appropriate care in most situations (Kosilek v. Massachusetts Department of Corrections/Maloney, C.A. No. 92-12820-MLW, 2002). People with gender dysphoria who are deemed appropriate for hormone therapy (following the *SOC*) should be started on such therapy. The consequences of abrupt withdrawal of hormones or lack of initiation of hormone therapy when medically necessary include a high likelihood of negative outcomes such as surgical self-treatment by autocastration, depressed mood, dysphoria, and/or suicidality (Brown, 2010).

Reasonable accommodations to the institutional environment can be made in the delivery of care consistent with the *SOC*, if such accommodations do not jeopardize the delivery of medically necessary care to people with gender dysphoria. An example of a reasonable accommodation is the use of injectable hormones, if not medically contraindicated, in an environment where diversion of oral preparations is highly likely (Brown, 2009). Denial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations under the *SOC* (Brown, 2010).

Housing and shower/bathroom facilities for transsexual, transgender, and gender nonconforming people living in institutions should take into account their gender identity and role, physical status, dignity, and personal safety. Placement in a single-sex housing unit, ward, or pod on the sole basis of the appearance of the external genitalia may not be appropriate and may place the individual at risk for victimization (Brown, 2009).

Institutions where transsexual, transgender, and gender nonconforming people reside and receive health care should monitor for a tolerant and positive climate to ensure that residents are not under attack by staff or other residents.

XV

Applicability of the Standards of Care to People With Disorders of Sex Development

Terminology

The term *disorder of sex development* (DSD) refers to a somatic condition of atypical development of the reproductive tract (Hughes, Houk, Ahmed, Lee, & LWPES1/ESPE2 Consensus Group, 2006). DSDs include the condition that used to be called *intersexuality*. Although the terminology was changed to *DSD* during an international consensus conference in 2005 (Hughes et al., 2006), disagreement about language use remains. Some people object strongly to the "disorder" label, preferring instead to view these congenital conditions as a matter of diversity (Diamond, 2009) and to continue using the terms *intersex* or *intersexuality*. In the *SOC*, WPATH uses the term *DSD* in an objective and value-free manner, with the goal of ensuring that health professionals recognize this medical term and use it to access relevant literature as the field progresses. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Rationale for Addition to the SOC

Previously, individuals with a DSD who also met the *DSM-IV-TR's* behavioral criteria for Gender Identity Disorder (American Psychiatric Association, 2000) were excluded from that general diagnosis. Instead, they were categorized as having a "Gender Identity Disorder - Not Otherwise Specified." They were also excluded from the WPATH *Standards of Care*.

The current proposal for *DSM-5* (www.dsm5.org) is to replace the term *gender identity disorder* with *gender dysphoria*. Moreover, the proposed changes to the *DSM* consider gender dysphoric people with a DSD to have a subtype of gender dysphoria. This proposed categorization – which explicitly differentiates between gender dysphoric individuals with and without a DSD – is justified: In people with a DSD, gender dysphoria differs in its phenomenological presentation, epidemiology, life trajectories, and etiology (Meyer-Bahlburg, 2009).

Adults with a DSD and gender dysphoria have increasingly come to the attention of health professionals. Accordingly, a brief discussion of their care is included in this version of the *SOC*.

Health History Considerations

Health professionals assisting patients with both a DSD and gender dysphoria need to be aware that the medical context in which such patients have grown up is typically very different from that of people without a DSD.

Some people are recognized as having a DSD through the observation of gender-atypical genitals at birth. (Increasingly this observation is made during the prenatal period by way of imaging procedures such as ultrasound.) These infants then undergo extensive medical diagnostic procedures. After consultation among the family and health professionals – during which the specific diagnosis, physical and hormonal findings, and feedback from long-term outcome studies (Cohen-Kettenis, 2005; Dessens, Slijper, & Drop, 2005; Jurgensen, Hiort, Holterhus, & Thyen, 2007; Mazur, 2005; Meyer-Bahlburg, 2005; Stikkelbroeck et al., 2003; Wisniewski, Migeon, Malouf, & Gearhart, 2004) are considered – the newborn is assigned a sex, either male or female.

Other individuals with a DSD come to the attention of health professionals around the age of puberty through the observation of atypical development of secondary sex characteristics. This observation also leads to a specific medical evaluation.

The type of DSD and severity of the condition has significant implications for decisions about a patient's initial sex assignment, subsequent genital surgery, and other medical and psychosocial care (Meyer-Bahlburg, 2009). For instance, the degree of prenatal androgen exposure in individuals with a DSD has been correlated with the degree of masculinization of gender-related *behavior* (that is, *gender role and expression*); however, the correlation is only moderate, and considerable behavioral variability remains unaccounted for by prenatal androgen exposure (Jurgensen et al., 2007; Meyer-Bahlburg, Dolezal, Baker, Ehrhardt, & New, 2006). Notably, a similar correlation of prenatal hormone exposure with gender *identity* has not been demonstrated (e.g., Meyer-Bahlburg et al., 2004). This is underlined by the fact that people with the same (core) gender identity can vary widely in the degree of masculinization of their gender-related behavior.

Assessment and Treatment of Gender Dysphoria in People with Disorders of Sex Development

Very rarely are individuals with a DSD identified as having gender dysphoria *before* a DSD diagnosis has been made. Even so, a DSD diagnosis is typically apparent with an appropriate history and basic physical exam – both of which are part of a medical evaluation for the appropriateness of hormone therapy or surgical interventions for gender dysphoria. Mental health professionals should ask their clients presenting with gender dysphoria to have a physical exam, particularly if they are not currently seeing a primary care (or other health care) provider.

Most people with a DSD who are born with genital ambiguity do not develop gender dysphoria (e.g., Meyer-Bahlburg et al., 2004; Wisniewski et al., 2004). However, some people with a DSD will develop chronic gender dysphoria and even undergo a change in their birth-assigned sex and/or their gender role (Meyer-Bahlburg, 2005; Wilson, 1999; Zucker, 1999). If there are persistent and strong indications that gender dysphoria is present, a comprehensive evaluation by clinicians skilled in the assessment and treatment of gender dysphoria is essential, irrespective of the patient's age. Detailed recommendations have been published for conducting such an assessment and for making treatment decisions to address gender dysphoria in the context of a DSD (Meyer-Bahlburg, in press). Only after thorough assessment should steps be taken in the direction of changing a patient's birth-assigned sex or gender role.

Clinicians assisting these patients with treatment options to alleviate gender dysphoria may profit from the insights gained from providing care to patients without a DSD (Cohen-Kettenis, 2010). However, certain criteria for treatment (e.g., age, duration of experience with living in the desired gender role) are usually not routinely applied to people with a DSD; rather, the criteria are interpreted in light of a patient's specific situation (Meyer-Bahlburg, in press). In the context of a DSD, changes in birth-assigned sex and gender role have been made at any age between early elementary-school age and middle adulthood. Even genital surgery may be performed much earlier in these patients than in gender dysphoric individuals without a DSD if the surgery is well justified by the diagnosis, by the evidence-based gender-identity prognosis for the given syndrome and syndrome severity, and by the patient's wishes.

One reason for these treatment differences is that genital surgery in individuals with a DSD is quite common in infancy and adolescence. Infertility may already be present due to either early gonadal failure or to gonadectomy because of a malignancy risk. Even so, it is advisable for patients with a DSD to undergo a full social transition to another gender role only if there is a long-standing history of gender-atypical behavior, and if gender dysphoria and/or the desire to change one's gender role has been strong and persistent for a considerable period of time. Six months is the time period of full symptom expression required for the application of the gender dysphoria diagnosis proposed for *DSM-5* (Meyer-Bahlburg, in press).

Additional Resources

The gender-relevant medical histories of people with a DSD are often complex. Their histories may include a great variety of inborn genetic, endocrine, and somatic atypicalities, as well as various hormonal, surgical, and other medical treatments. For this reason, many additional issues need to be considered in the psychosocial and medical care of such patients, regardless of the presence of gender dysphoria. Consideration of these issues is beyond what can be covered in the *SOC*. The interested reader is referred to existing publications (e.g., Cohen-Kettenis & Pfäfflin, 2003; Meyer-Bahlburg, 2002, 2008). Some families and patients also find it useful to consult or work with community support groups.

There is a very substantial medical literature on the medical management of patients with a DSD. Much of this literature has been produced by high-level specialists in pediatric endocrinology and urology, with input from specialized mental health professionals, especially in the area of gender. Recent international consensus conferences have addressed evidence-based care guidelines (including issues of gender and of genital surgery) for DSD in general (Hughes et al., 2006) and specifically for Congenital Adrenal Hyperplasia (Joint LWPES/ESPE CAH Working Group et al., 2002; Speiser et al., 2010). Others have addressed the research needs for DSD in general (Meyer-Bahlburg & Blizzard, 2004) and for selected syndromes such as 46,XXY (Simpson et al., 2003).

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APPENDIX A
GLOSSARY

Terminology in the area of health care for transsexual, transgender, and gender nonconforming people is rapidly evolving; new terms are being introduced, and the definitions of existing terms are changing. Thus, there is often misunderstanding, debate, or disagreement about language in this field. Terms that may be unfamiliar or that have specific meanings in the *SOC* are defined below for the purpose of this document only. Others may adopt these definitions, but WPATH acknowledges that these terms may be defined differently in different cultures, communities, and contexts.

WPATH also acknowledges that many terms used in relation to this population are not ideal. For example, the terms *transsexual* and *transvestite* – and, some would argue, the more recent term *transgender* – have been applied to people in an objectifying fashion. Yet such terms have been more or less adopted by many people who are making their best effort to make themselves understood. By continuing to use these terms, WPATH intends only to ensure that concepts and processes are comprehensible, in order to facilitate the delivery of quality health care to transsexual, transgender, and gender nonconforming people. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Bioidentical hormones*:* Hormones that are *structurally* identical to those found in the human body (ACOG Committee of Gynecologic Practice, 2005). The hormones used in bioidentical hormone therapy (BHT) are generally derived from plant sources and are structurally similar to endogenous human hormones, but they need to be commercially processed to become bioidentical.

Bioidentical compounded hormone therapy (BCHT): Use of hormones that are prepared, mixed, assembled, packaged, or labeled as a drug by a pharmacist and custom-made for a patient according to a physician's specifications. Government drug agency approval is not possible for each compounded product made for an individual consumer.

Crossdressing (transvestism): Wearing clothing and adopting a gender role presentation that, in a given culture, is more typical of the other sex.

Disorders of sex development (DSD): Congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Some people strongly object to the "disorder" label and instead view these conditions as a matter of diversity (Diamond, 2009), preferring the terms *intersex* and *intersexuality*.

Female-to-Male (FtM): Adjective to describe individuals assigned female at birth who are changing or who have changed their body and/or gender role from birth-assigned female to a more masculine body or role.

Gender dysphoria: Distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

Gender identity: A person's intrinsic sense of being male (a boy or a man), female (a girl or woman), or an alternative gender (e.g., boygirl, girlboy, transgender, genderqueer, eunuch) (Bockting, 1999; Stoller, 1964).

Gender identity disorder: Formal diagnosis set forth by the *Diagnostic Statistical Manual of Mental Disorders, 4th Edition, Text Rev (DSM IV-TR)* (American Psychiatric Association, 2000). Gender identity disorder is characterized by a strong and persistent cross-gender identification and a persistent discomfort with one's sex or sense of inappropriateness in the gender role of that sex, causing clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Gender nonconforming: Adjective to describe individuals whose gender identity, role, or expression differs from what is normative for their assigned sex in a given culture and historical period.

Gender role or expression: Characteristics in personality, appearance, and behavior that in a given culture and historical period are designated as masculine or feminine (that is, more typical of the male or female social role) (Ruble, Martin, & Berenbaum, 2006). While most individuals present socially in clearly male or female gender roles, some people present in an alternative gender role such as genderqueer or specifically transgender. All people tend to incorporate both masculine and feminine characteristics in their gender expression in varying ways and to varying degrees (Bockting, 2008).

Genderqueer: Identity label that may be used by individuals whose gender identity and/or role does not conform to a binary understanding of gender as limited to the categories of man or woman, male or female (Bockting, 2008).

Male-to-Female (MtF): Adjective to describe individuals assigned male at birth who are changing or who have changed their body and/or gender role from birth-assigned male to a more feminine body or role.

Natural hormones: Hormones that are derived from natural *sources* such as plants or animals. Natural hormones may or may not be bioidentical.

Sex: Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia. When the external genitalia are ambiguous, other components of sex (internal genitalia, chromosomal and hormonal sex) are considered in order to assign sex (Grumbach, Hughes, & Conte,

2003; MacLaughlin & Donahoe, 2004; Money & Ehrhardt, 1972; Vilain, 2000). For most people, gender identity and expression are consistent with their sex assigned at birth; for transsexual, transgender, and gender nonconforming individuals, gender identity or expression differ from their sex assigned at birth.

Sex reassignment surgery (gender affirmation surgery): Surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity. Sex reassignment surgery can be an important part of medically necessary treatment to alleviate gender dysphoria.

Transgender: Adjective to describe a diverse group of individuals who cross or transcend culturally-defined categories of gender. The gender identity of transgender people differs to varying degrees from the sex they were assigned at birth (Bockting, 1999).

Transition: Period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role. For many people, this involves learning how to live socially in "the other" gender role; for others this means finding a gender role and expression that is most comfortable for them. Transition may or may not include feminization or masculinization of the body through hormones or other medical procedures. The nature and duration of transition is variable and individualized.

Transphobia, internalized: Discomfort with one's own transgender feelings or identity as a result of internalizing society's normative gender expectations.

Transsexual: Adjective (often applied by the medical profession) to describe individuals who seek to change or who have changed their primary and/or secondary sex characteristics through femininizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role.

APPENDIX B
OVERVIEW OF MEDICAL RISKS OF HORMONE THERAPY

The risks outlined below are based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (e.g., Dahl et al., 2006; Ettner et al., 2007).

Risks of Feminizing Hormone Therapy (MtF)

Likely increased risk:

Venous thromboembolic disease

- Estrogen use increases the risk of venous thromboembolic events (VTE), particularly in patients who are over age 40, smokers, highly sedentary, obese, and who have underlying thrombophilic disorders.
- This risk is increased with the additional use of third generation progestins.
- This risk is decreased with use of the transdermal route of estradiol administration, which is recommended for patients at higher risk of VTE.

Cardiovascular, cerebrovascular disease

- Estrogen use increases the risk of cardiovascular events in patients over age 50 with underlying cardiovascular risk factors. Additional progestin use may increase this risk.

Lipids

- Oral estrogen use may markedly increase triglycerides in patients, increasing the risk of pancreatitis and cardiovascular events.
- Different routes of administration will have different metabolic effects on levels of HDL cholesterol, LDL cholesterol and lipoprotein(a).
- In general, clinical evidence suggests that MtF patients with pre-existing lipid disorders may benefit from the use of transdermal rather than oral estrogen.

Liver/gallbladder

- Estrogen and cyproterone acetate use may be associated with transient liver enzyme elevations and, rarely, clinical hepatotoxicity.
- Estrogen use increases the risk of cholelithiasis (gall stones) and subsequent cholecystectomy.

Possible increased risk:

Type 2 diabetes mellitus

- Feminizing hormone therapy, particularly estrogen, may increase the risk of type 2 diabetes, particularly among patients with a family history of diabetes or other risk factors for this disease.

Hypertension

- Estrogen use may increase blood pressure, but the effect on incidence of overt hypertension is unknown.
- Spironolactone reduces blood pressure and is recommended for at-risk or hypertensive patients desiring feminization.

Prolactinoma

- Estrogen use increases the risk of hyperprolactinemia among MtF patients in the first year of treatment, but this risk unlikely thereafter.
- High-dose estrogen use may promote the clinical appearance of preexisting but clinically unapparent prolactinoma.

Inconclusive or no increased risk: Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Breast cancer

- MtF persons who have taken feminizing hormones do experience breast cancer, but it is unknown how their degree of risk compares to that of persons born with female genitalia.
- Longer duration of feminizing hormone exposure (i.e., number of years taking estrogen preparations), family history of breast cancer, obesity (BMI >35), and the use of progestins likely influence the level of risk.

Other side effects of feminizing therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with feminizing hormone therapy.

Fertility and sexual function

- Feminizing hormone therapy may impair fertility.
- Feminizing hormone therapy may decrease libido.
- Feminizing hormone therapy reduces nocturnal erections, with variable impact on sexually stimulated erections.

Risks of anti-androgen medications:

Feminizing hormone regimens often include a variety of agents that affect testosterone production or action. These include GnRH agonists, progestins (including cyproterone acetate), spironolactone, and 5-alpha reductase inhibitors. An extensive discussion of the specific risks of these agents is beyond the scope of the *SOC*. However, both spironolactone and cyproterone acetate are widely used and deserve some comment.

Cyproterone acetate is a progestational compound with anti-androgenic properties (Gooren, 2005; Levy et al., 2003). Although widely used in Europe, it is not approved for use in the United States because of concerns about hepatotoxicity (Thole, Manso, Salgueiro, Revuelta, & Hidalgo, 2004). Spironolactone is commonly used as an anti-androgen in feminizing hormone therapy, particularly in regions where cyproterone is not approved for use (Dahl et al., 2006; Moore et al., 2003; Tangpricha et al., 2003). Spironolactone has a long history of use in treating hypertension and congestive heart failure. Its common side effects include hyperkalemia, dizziness, and gastrointestinal symptoms (*Physicians' Desk Reference*, 2007).

Risks of Masculinizing Hormone Therapy (FtM)

Likely increased risk:

Polycythemia

- Masculinizing hormone therapy involving testosterone or other androgenic steroids increases the risk of polycythemia (hematocrit > 50%), particularly in patients with other risk factors.
- Transdermal administration and adaptation of dosage may reduce this risk

Weight gain/visceral fat

- Masculinizing hormone therapy can result in modest weight gain, with an increase in visceral fat.

Possible increased risk:

Lipids

- Testosterone therapy decreases HDL, but variably affects LDL and triglycerides.
- Supraphysiologic (beyond normal male range) serum levels of testosterone, often found with extended intramuscular dosing**,** may worsen lipid profiles, whereas transdermal administration appears to be more lipid neutral.
- Patients with underlying polycystic ovarian syndrome or dyslipidemia may be at increased risk of worsening dyslipidemia with testosterone therapy.

Liver

- Transient elevations in liver enzymes may occur with testosterone therapy.
- Hepatic dysfunction and malignancies have been noted with oral methyltestosterone. However, methyltestosterone is no longer available in most countries and should no longer be used.

Psychiatric

Masculinizing therapy involving testosterone or other androgenic steroids may increase the risk of hypomanic, manic, or psychotic symptoms in patients with underlying psychiatric disorders that include such symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone

Inconclusive or no increased risk: Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Osteoporosis

- Testosterone therapy maintains or increases bone mineral density among FtM patients prior to oophorectomy, at least in the first three years of treatment.
- There is an increased risk of bone density loss after oophorectomy, particularly if testosterone therapy is interrupted or insufficient. This includes patients utilizing solely oral testosterone.

Cardiovascular

- Masculinizing hormone therapy at normal physiologic doses does not appear to increase the risk of cardiovascular events among healthy patients.
- Masculinizing hormone therapy may increase the risk of cardiovascular disease in patients with underlying risks factors.

Hypertension

- Masculinizing hormone therapy at normal physiologic doses may increase blood pressure but does not appear to increase the risk of hypertension.
- Patients with risk factors for hypertension, such as weight gain, family history, or polycystic ovarian syndrome, may be at increased risk.

Type 2 diabetes mellitus

- Testosterone therapy does not appear to increase the risk of type 2 diabetes among FtM patients overall.

- Testosterone therapy may further increase the risk of type 2 diabetes in patients with other risk factors, such as significant weight gain, family history, and polycystic ovarian syndrome. There are no data that suggest or show an increase in risk in those with risk factors for dyslipidemia.

Breast cancer

- Testosterone therapy in FtM patients does not increase the risk of breast cancer.

Cervical cancer

- Testosterone therapy in FtM patients does not increase the risk of cervical cancer, although it may increase the risk of minimally abnormal Pap smears due to atrophic changes.

Ovarian cancer

- Analogous to persons born with female genitalia with elevated androgen levels, testosterone therapy in FtM patients may increase the risk of ovarian cancer, although evidence is limited.

Endometrial (uterine) cancer

- Testosterone therapy in FtM patients may increase the risk of endometrial cancer, although evidence is limited.

Other side effects of masculinizing therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with masculinization.

Fertility and sexual function

- Testosterone therapy in FtM patients reduces fertility, although the degree and reversibility are unknown.
- Testosterone therapy can induce permanent anatomic changes in the developing embryo or fetus.
- Testosterone therapy induces clitoral enlargement and increases libido.

Acne, androgenic alopecia

Acne and varying degrees of male pattern hair loss (androgenic alopecia) are common side effects of masculinizing hormone therapy.

APPENDIX C
SUMMARY OF CRITERIA FOR HORMONE THERAPY AND SURGERIES

As for all previous versions of the *SOC*, the criteria put forth in the *SOC* for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable to accumulate new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

Criteria for Feminizing/Masculinizing Hormone Therapy (one referral or chart documentation of psychosocial assessment)

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental concerns are present, they must be reasonably well-controlled.

Criteria for Breast/Chest Surgery (one referral)

Mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a pre-requisite.

Breast augmentation (implants/lipofilling) in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for genital surgery (two referrals)

Hysterectomy and ovariectomy in FtM patients and orchiectomy in MtF patients:

1. Persistent, well documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country;

4. If significant medical or mental health concerns are present, they must be well controlled;

5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before a patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these surgical procedures for medical indications other than gender dysphoria.

Metoidioplasty or phalloplasty in FtM patients and vaginoplasty in MtF patients:

1. Persistent, well documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country;

4. If significant medical or mental health concerns are present, they must be well controlled;

5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones);

6. 12 continuous months of living in a gender role that is congruent with their gender identity.

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery.

APPENDIX D
EVIDENCE FOR CLINICAL OUTCOMES OF THERAPEUTIC APPROACHES

One of the real supports for any new therapy is an outcome analysis. Because of the controversial nature of sex reassignment surgery, this type of analysis has been very important. Almost all of the outcome studies in this area have been retrospective.

One of the first studies to examine the post-treatment psychosocial outcomes of transsexual patients was done in 1979 at Johns Hopkins University School of Medicine and Hospital (USA) (J. K. Meyer & Reter, 1979). This study focused on patients' occupational, educational, marital, and domiciliary stability. The results revealed several significant changes with treatment. These changes were not seen as positive; rather, they showed that many individuals who had entered the treatment program were no better off or were worse off in many measures after participation in the program. These findings resulted in closure of the treatment program at that hospital/medical school (Abramowitz, 1986).

Subsequently, a significant number of health professionals called for a standard for eligibility for sex reassignment surgery. This led to the formulation of the original *Standards of Care* of the Harry Benjamin International Gender Dysphoria Association (now WPATH) in 1979.

In 1981, Pauly published results from a large retrospective study of people who underwent sex reassignment surgery. Participants in that study had much better outcomes: Among 83 FtM patients, 80.7% had a satisfactory outcome (i.e., patient self report of "improved social and emotional adjustment"), 6.0% unsatisfactory. Among 283 MtF patients, 71.4% had a satisfactory outcome, 8.1% unsatisfactory. This study included patients who were treated before the publication and use of the *Standards of Care*.

Since the *Standards of Care* have been in place, there has been a steady increase in patient satisfaction and decrease in dissatisfaction with the outcome of sex reassignment surgery. Studies conducted after 1996 focused on patients who were treated according to the *Standards of Care*. The findings of Rehman and colleagues (1999) and Krege and colleagues (2001) are typical of this body of work; none of the patients in these studies regretted having had surgery, and most reported being satisfied with the cosmetic and functional results of the surgery. Even patients who develop severe surgical complications seldom regret having undergone surgery. Quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2003). The vast majority of follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Garaffa, Christopher, & Ralph, 2010; Klein & Gorzalka, 2009), although the specific magnitude of benefit is uncertain from

the currently available evidence. One study (Emory, Cole, Avery, Meyer, & Meyer III, 2003) even showed improvement in patient income.

One troubling report (Newfield et al., 2006) documented lower scores on quality of life (measured with the SF-36) for FtM patients than for the general population. A weakness of that study is that it recruited its 384 participants by a general email rather than a systematic approach, and the degree and type of treatment was not recorded. Study participants who were taking testosterone had typically being doing so for less than 5 years. Reported quality of life was higher for patients who had undergone breast/chest surgery than for those who had not ($p<.001$). (A similar analysis was not done for genital surgery). In other work, Kuhn and colleagues (2009) used the King's Health Questionnaire to assess the quality of life of 55 transsexual patients at 15 years after surgery. Scores were compared to those of 20 healthy female control patients who had undergone abdominal/pelvic surgery in the past. Quality of life scores for transsexual patients were the same or better than those of control patients for some subscales (emotions, sleep, incontinence, symptom severity, and role limitation), but worse in other domains (general health, physical limitation, and personal limitation).

It is difficult to determine the effectiveness of hormones alone in the relief of gender dysphoria. Most studies evaluating the effectiveness of masculinizing/feminizing hormone therapy on gender dysphoria have been conducted with patients who have also undergone sex reassignment surgery. Favorable effects of therapies that included both hormones and surgery were reported in a comprehensive review of over 2000 patients in 79 studies (mostly observational) conducted between 1961 and 1991 (Eldh, Berg, & Gustafsson, 1997; Gijs & Brewaeys, 2007; Murad et al., 2010; Pfäfflin & Junge, 1998). Patients operated on after 1986 did better than those before 1986; this reflects significant improvement in surgical complications (Eldh et al., 1997). Most patients have reported improved psychosocial outcomes, ranging between 87% for MtF patients and 97% for FtM patients (Green & Fleming, 1990). Similar improvements were found in a Swedish study in which "almost all patients were satisfied with sex reassignment at 5 years, and 86% were assessed by clinicians at follow-up as stable or improved in global functioning" (Johansson, Sundbom, Höjerback, & Bodlund, 2010). Weaknesses of these earlier studies are their retrospective design and use of different criteria to evaluate outcomes.

A prospective study conducted in the Netherlands evaluated 325 consecutive adult and adolescent subjects seeking sex reassignment (Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005). Patients who underwent sex reassignment therapy (both hormonal and surgical intervention) showed improvements in their mean gender dysphoria scores, measured by the Utrecht Gender Dysphoria Scale. Scores for body dissatisfaction and psychological function also improved in most categories. Fewer than 2% of patients expressed regret after therapy. This is the largest prospective study to affirm the results from retrospective studies that a combination of hormone therapy and surgery improves gender dysphoria and other areas of psychosocial functioning. There is a need for further research on the effects of hormone therapy without surgery, and without the goal of maximum physical feminization or masculinization.

Overall, studies have been reporting a steady improvement in outcomes as the field becomes more advanced. Outcome research has mainly focused on the outcome of sex reassignment surgery. In current practice there is a range of identity, role, and physical adaptations that could use additional follow-up or outcome research (Institute of Medicine, 2011).

APPENDIX E
DEVELOPMENT PROCESS FOR THE STANDARDS OF CARE, VERSION 7

The process of developing *Standards of Care, Version 7* began when an initial *SOC* "work group" was established in 2006. Members were invited to examine specific sections of *SOC, Version 6*. For each section, they were asked to review the relevant literature, identify where research was lacking and needed, and recommend potential revisions to the *SOC* as warranted by new evidence. Invited papers were submitted by the following authors: Aaron Devor, Walter Bockting, George Brown, Michael Brownstein, Peggy Cohen-Kettenis, Griet DeCuypere, Petra DeSutter, Jamie Feldman, Lin Fraser, Arlene Istar Lev, Stephen Levine, Walter Meyer, Heino Meyer-Bahlburg, Stan Monstrey, Loren Schechter, Mick van Trotsenburg, Sam Winter, and Ken Zucker. Some of these authors chose to add co-authors to assist them in their task.

Initial drafts of these papers were due June 1, 2007. Most were completed by September 2007, with the rest completed by the end of 2007. These manuscripts were then submitted to the *International Journal of Transgenderism (IJT)*. Each underwent the regular *IJT* peer review process. The final papers were published in Volume 11 (1-4) in 2009, making them available for discussion and debate.

After these articles were published, a *Standards of Care* Revision Committee was established by the WPATH Board of Directors in 2010. The Revision Committee was first charged with debating and discussing the *IJT* background papers through a Google website. A subgroup of the Revision Committee was appointed by the Board of Directors to serve as the Writing Group. This group was charged with preparing the first draft of *SOC, Version 7* and continuing to work on revisions for consideration by the broader Revision Committee. The Board also appointed an International Advisory Group of transsexual, transgender, and gender nonconforming individuals to give input on the revision.

A technical writer was hired to (1) review all of the recommendations for revision – both the original recommendations as outlined in the *IJT* articles and additional recommendations that emanated from the online discussion – and (2) create a survey to solicit further input on these potential revisions. From the survey results, the Writing Group was able to discern where these experts stood in terms of areas of agreement and areas in need of more discussion and debate. The technical writer then (3) created a very rough first draft of *SOC, Version 7* for the Writing Group to consider and build on.

The Writing Group met on March 4 and 5, 2011 in a face-to-face expert consultation meeting. They reviewed all recommended changes and debated and came to consensus on various controversial areas. Decisions were made based on the best available science and expert consensus. These decisions were incorporated into the draft, and additional sections were written by the Writing Group with the assistance of the technical writer.

The draft that emerged from the consultation meeting was then circulated among the Writing Group and finalized with the help of the technical writer. Once this initial draft was finalized it was circulated among the broader *SOC* Revision Committee and the International Advisory Group. Discussion was opened up on the Google website and a conference call was held to resolve issues. Feedback from these groups was considered by the Writing Group, who then made further revision. Two additional drafts were created and posted on the Google website for consideration by the broader *SOC* Revision Committee and the International Advisory Group. Upon completion of these three iteratations of review and revision, the final document was presented to the WPATH Board of Directors for approval. The Board of Directors approved this version on September 14, 2011.

The plans are to disseminate this version of the *SOC* and invite feedback for further revisions. The WPATH Board of Directors decides the timing of any revision of the *SOC*.

Funding

The *Standards of Care* revision process was made possible through a generous grant from the Tawani Foundation and a gift from an anonymous donor. These funds supported the following:

1. Costs of a professional technical writer;

2. Process of soliciting international input on proposed changes from gender identity professionals and the transgender community;

3. Working meeting of the Writing Group;

4. Process of gathering additional feedback and arriving at final expert consensus from the professional and transgender communities, the *Standards of Care, Version 7* Revision Committee, and WPATH Board of Directors;

5. Costs of printing and distributing *Standards of Care, Version 7* and posting a free downloadable copy on the WPATH website;

6. Plenary session to launch the *Standards of Care, Version 7* at the 2011 WPATH Biennial Symposium in Atlanta, Georgia, USA.

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION

Civil Action No. 3:22-cv-0191

KANAUTICA ZAYRE-BROWN,)
)
Plaintiff,)
)
v.)
)
THE NORTH CAROLINA)
DEPARTMENT OF PUBLIC)
SAFETY, et al.,)
)
Defendants.)
)

30(b)(6) DEPOSITION OF ARTHUR CAMPBELL, M.D.
THE NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY

(Taken by plaintiff.)

Raleigh, North Carolina

April 18, 2023, 9:30 a.m.

Reported By:
SUSAN GALLAGHER, CA CSR, CVR-CM

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DEPOSITION OF ARTHUR CAMPBELL, M.D., a witness called before SUSAN GALLAGHER, CA CSR, CVR-CM, a Notary Public in and for the State of North Carolina, at 114 West Edenton Street, Raleigh, North Carolina, on Tuesday the 17th of April, 2023, commencing at 9:30 a.m.

Raleigh, North Carolina

EXAMINATION

BY MS. MAFFETORE:

Q Good morning, Dr. Campbell. We just met. My name is Jaci Maffetore. I'm an attorney with the ACLU of North Carolina. I represent Kanautica Zayre-Brown, the plaintiff in this matter.

To begin, could you please state and spell your full name for the record?

A Okay. Arthur Leslie Campbell, III. A-R-T-H-U-R, L-E-S-L-I-E, C-A-M-P-B-E-L-L, the third.

Q Okay. And may I call you "Dr. Campbell"?

A Sure.

Q Okay. So I want to first acknowledge for the record that since this lawsuit began, the North Carolina Department of Public Safety has undergone an organizational transformation shift in that the prisons division of that department is now called the Department of Adult Corrections. For purposes of this deposition though, I will be referring to those that are now under the Department of Adult Corrections as the North Carolina Department of Public Safety or DPS just so that we're all on the same page because that is the structure that was in place when this action was instituted.

I also want to note for the record I am deposing you, Dr. Campbell. Though you are a defendant in this matter, I'm first going to be deposing you in your capacity as a 30(b)(6) designee on behalf of DPS and not in your capacity as a defendant and witness in this case. I will then depose you in your as a defendant and witness afterward, but I will make clear for the record when the 30(b)(6) deposition has concluded.

A Okay.

Q So first, I just want to ask, have you ever been deposed before?

A Yes, ma'am.

Q Okay. Roughly how many times?

A At least four.

Q Okay. So this is not new to you, but I nonetheless would just like to lay some ground rules that we'll be operating using today, just to make sure that we're all on the same page, to make sure that the deposition runs smoothly, and make sure that the court reporter can get down everything that we're saying, just make her job a little easier. Is that okay with you?

A It is.

Q So first I ask that you answer each of my

slightly different now; is that correct?

A Correct. He's now the deputy secretary.

Q Did you have any involvement in drafting this policy?

A No, ma'am.

Q Have you ever been asked to contribute to any revisions of the policy?

A No, ma'am.

Q If you could please look at page 1 of this exhibit, Section 2C at the bottom, do you see a portion that says, "In support of DOP's mission statement, health and wellness professionals shall promote excellence, provide community-consistent cost effective quality healthcare throughout our system."

Did I read that accurately?

A Yes, ma'am.

Q What does DOP mean by "community consistent healthcare"?

A So, again, they -- well, we are expected to provide our services that are consistent with standards of care or community practice. So there is a little bit of a distinction between what's the standard of care as opposed to following clinical practice guidelines, but that's the consistency there. So we need to be consistent with what the community is doing.

In other words, offenders should receive the exact same care they would get if they were on the outside.

Q Okay. You mentioned just now some distinction between standards of care and clinical guidelines. Could you elaborate on that?

A Sure. Standard of care is, quite frankly, more of a legal term than a medical term. So in the medical community, what we rely on and what the vast majority of all of the professional medical societies publish are clinical practice guidelines. They don't call them standard of care, per se.

So the best medical definition of standard of care would be the diagnostic or treatment procedures that a clinician should follow in treating a particular patient, illness, or a particular clinical circumstance. Legally it has a little bit different twist, and my interpretation of a legal definition of that would be that it's, how would the average the prudent provider provide care for that specific patient in those circumstances, or how would a similarly qualified and trained clinician provide care for a particular patient in those exact clinical circumstances.

Q Okay. Now, when you say that folks that are incarcerated should receive the same care in prison as

we are supposed to take care of these offenders. That's where I became aware of what that standard is.

Q Does DPS provide training to its health services staff members regarding the meaning of community consistent care?

A I don't know if there's any specific training for that. You obviously review policies and procedures, and you have orientation when you arrive at the organization, and that's part of that, but I don't know if there's a specific training dedicated to this particular aspect of that.

Q Okay. From your understanding or from DPS's understanding, is medically necessary care the same as community consistent care?

A Generally, yes.

Q You said "generally, yes." Are there circumstances when that is not the case?

A Well, I think the difference would be in the community, individuals can pay for care that may be elective. Whereas, in the prison, we are responsible for providing that care.

Q I'm not sure I understand -- I'm not sure I understand that answer. So that's a situation where medically necessary care and community consistent care would not be similar is where elective procedures are

the accepted standard, really, everywhere for what medical necessity is.

Q So you mentioned certain factors that are taken into account regarding medical necessity. Does DPS ever take into consideration the cost of a procedure when it's considering medical necessity?

A No.

Q How about security?

A Security is always considered in every context in our setting.

Q So it's considered a medical necessity determination?

A It's not a medical necessity determination, no, but security's always a determination.

Q Okay. How about logistics?

A Again, not for medical necessity, if that's what you're asking.

Q What about the ability to provide postoperative care?

A Again, not for medical necessity.

Q Is your interpretation as medical director on behalf of DPS of medical necessity the same for all DPS decisions about the provision of, for example, mental health care?

MR. RODRIGUEZ: Object to speculation.

You can answer.

THE WITNESS: It's universal when it relates to health care, regardless of the type of healthcare.

BY MS. MAFFETORE:

Q So also all medical care, all sorts of care?

MR. RODRIGUEZ: Same objection. Speculation.

You can answer.

THE WITNESS: Yes.

BY MS. MAFFETORE:

Q And in evaluating the request from someone in DPS custody for healthcare services, is there any kind of care where DPS would consider an individual's legal history in making a medical necessity determination?

A No, ma'am.

Q Is there any situation where DPS would consider an individual's criminal record in making a medical necessity determination?

A No, ma'am.

Q Is there any instance where DPS would consider an individual's disciplinary history or history of interactions in a medical necessity determination?

A No, ma'am.

Q If you to turn to page 2 of Exhibit 3, if you'll look at Section 2G5, it states there that "one of the goals of health and wellness is to engage in

sound healthcare practices that meet an acceptable standard of care"; correct?

A Correct.

Q So I think that you started to get into this when you were talking about medical necessity, but if you could get into it now, what constitutes an acceptable standard of care according to DPS?

A So, again, within DPS we rely on the same things I mentioned, which are clinical practice guidelines, and that is across the board what we rely on for standard of care.

Q What are the sources of those clinical practice guidelines?

A They will vary. It can be from the individual professional medical associations and societies. We often develop our own clinical practice guidelines specific for our individual setting. Each one of those references the pertinent medical society clinical practice guidelines, and we'll adapt those as needed for the prison environment.

Q Are there any circumstances where DPS would not look to individual medical associations and societies for clinical guidelines?

MR. RODRIGUEZ WITNESS: Object to speculation.

You can answer.

THE WITNESS: No, ma'am.

BY MS. MAFFETORE:

Q Okay. So on the same page of this exhibit, Section 2H, it states that "the provision of treatment regarding clinical decisions that involve health and wellness providers are the sole responsibility of the managing health and wellness practitioner and are not reversed by non-clinicians."

Did I read that correctly?

A Yes, ma'am.

Q What does DPS mean by this?

A So it means that medical decisions are made by medical authorities within the prison.

Q Okay. How does DPS define "clinician"?

A It is a licensed independent provider. So it's a provider who is credentialed to practice within our healthcare system.

Q So you said is a licensed health provider. What degrees of licensure does that encompass?

A So it can be family nurse practitioners, physician assistants, and physicians.

Q Anyone else?

A No.

Q Would a mental health care provider be considered a clinician?

Q How do you determine if a resource meets the criteria that you just described?

A So, again, I think that you can look to the professional medical organizations that I talked about, and they're going to reference a lot of those, and I so I think you're already starting with reliable sources when you do your analysis.

Q So you generally consider those professional medical associations to be reliable?

A Yes, ma'am.

Q You can set that aside for now. Actually, I don't think we'll come back to that.

Does DPS facilitate surgery for those in its custody with outside specialists?

A Yes, ma'am.

Q How do DPS facilities typically coordinate the logistics of surgical procedures to be performed on those in custody that will be performed by outside specialists?

A The logistics?

Q Yes.

A So the logistics of -- so there's a referral that's made, just like happens anywhere else in the community. There's a -- the primary care provider will make a referral, in this case, to a surgical

specialist. That offender will then be transported to be evaluated. Some of them are done virtually, of course, but it's either by virtual appointment or an in-person appointment with a surgeon.

The surgeon will evaluate the offender, come up with some treatment recommendations, and provide those recommendations back to the agency. Those are reviewed by the agency as part of the utilization review process, and if the surgery is approved, then it is scheduled, and, again, the offender is transported and taken for that procedure by that provider.

Q So DPS does usually arrange for that transportation to a surgical procedure or a consult?

A Yes, ma'am.

Q Okay. Does DPS usually coordinate staff escorts and supervision of people who are receiving consults for surgical procedures?

A Yes, ma'am. It's a mandate.

Q Does DPS coordinate postsurgical observation?

A Yes, ma'am.

Q How does the type of surgical procedure performed factor into these logistical considerations?

A I don't know that it factors into those considerations. Obviously, there is going to have to be coordination by the custody staff. If an

individual, for instance, is going to be in the hospital for an extended period of time, there has to be coordination made with the correction officers to be able to provide supervision. But it's -- the decision as to whether or not to perform the surgery or how long postop care is necessary is not a decision made by -- it's not a decision. It's what's required for that offender, and we just have to accommodate that.

Q So even if there is a lengthy postoperative observation required, like, in a hospital offsite, DPS will make sure that the logistics are in place to allow for that?

A Yes, ma'am.

Q Okay. I am now going to hand to the court reporter to be marked what will be Exhibit No. 4.

(Exhibit 4 marked for identification.)

BY MS. MAFFETORE:

Q And Exhibit No. 4 is a policy entitled "Utilization Management." So, Dr. Campbell, you now have what the court reporter has marked for me as Plaintiff's Exhibit 4. Do you recognize this policy?

A Yes, ma'am.

Q And what is it?

A It is the Utilization Management Policy for the Department of Adult Correction.

okay, we're probably going to need more endocrinologists, or we needed to do some more evaluation at the primary care level or some more training or reinforcement at the primary care level before we make referrals to specialists, for instance. So we process upwards of 100,000 of these UR requests every year, and they run the gamut of every possible scenario you can think of in a prison. So it's, you know, from imaging studies to laboratory studies to pharmacologic interventions, to specialty referrals, surgical procedures. You know, it runs the gamut.

Q Okay.

A And all of those can feed into a quality assurance, quality improvement initiatives.

Q So looking at Section 1 under "purpose," it states that "the Division of Prisons Health and Wellness Utilization Management is designed to evaluate the appropriateness and medical necessity of services provided to offenders."

Did I read that correctly?

A Yes, ma'am.

Q What criteria does the UM use to determine medical necessity?

A Again, it would be the same criteria, the generally accepted medical criteria that I told you,

that it's reasonable and necessary to protect life, to prevent significant illness and disability, or to alleviate significant pain and suffering.

Q Are, again, those criteria the same for all medical services that the utilization management considers?

A Yes, ma'am.

Q Is the medical necessity determination within the sole discretion of utilization management?

A It is.

Q How does the treating physician's prescription or recommendation weigh into the utilization management determination about medical necessity?

A So it's critical. They're the entry point for the referral into the utilization management system. So it will either be a specialty provider from outside the prison, or it will be one of our primary care providers, and they enter all the pertinent clinical data and basically a justification for what the procedure or intervention they're asking for, and that is sent to utilization management for review.

Q So you said that it's critical that the provider provides justification to utilization management. To what degree does utilization management defer to the provider's justification if the provider

is representing they believe something to be a medical necessity?

MR. RODRIGUEZ: Object to the form.

You can answer.

THE WITNESS: So I think there's a lot of variables in that to determine. So, for instance, if it is -- it's a nurse practitioner or physician assistant that makes a referral, you know, the reviewers that do this are physicians, and they say they made a referral to see a specialist, and the physician reviewing that case reviews that, reviews the records, and determines that there wasn't the appropriate primary care workup that was required to send that person to a specialist, then it will be deferred back to that provider with recommendations on some things they need to do to further evaluate or treat this condition before they see a specialist.

Q What if the person making the UR request is themselves a physician? Does that change the calculus at all?

A No, ma'am. Physicians can not have done appropriate workup either.

Q Okay. So in that circumstance the members of the utilization management can override the recommendation of a treating physician?

MR. RODRIGUEZ: Object to the form.

You can answer.

THE WITNESS: No, ma'am. It is another physician. So it is not an administrative person. So these are senior physicians that serve in these roles as utilization review authorities. So they are senior to every other provider who is going to be submitting a request, regardless of whether they're a physician or not.

BY MS. MAFFETORE:

Q Understood. But the physicians that serve on utilization management are empowered to override the decision of a treating physician, somebody who has direct contact with a patient, for example?

MR. RODRIGUEZ: Object to the form.

You can answer.

THE WITNESS: I wouldn't call it an override. So that's really not what they're doing. So they will often ask -- for instance, they will often send it back with some clinical questions. So they may send it back with questions for the providers. Say the provider did not include some pertinent information to be able to make a decision, they will send it back to that provider and ask them to provide that information, or they may defer it back to the provider for the same

reasons I talked about. They may say, "We need updated imaging studies. We need -- the MRI is five years old, and it's not sufficient for an orthopedic surgeon to evaluate their spine. We need a new MRI."

So, again, I don't want to use the word "override," but it's to make sure that the case is clinically ready for whatever intervention they're asking for.

BY MS. MAFFETORE:

Q How does cost factor into the utilization management determination about medical necessity?

A It doesn't. I guess the only exception might be, for instance, with pharmacologic interventions. So we do have -- just like any other system out there, we do have a tiered level of pharmacologic interventions that we need to satisfy that. So there's a pharmacy and therapeutics committee that we have within prisons that determines what are the appropriate treatments.

So there can be times where -- and a factor in that PNT committee is cost, but you balance that cost with the efficacy of the medication. So there are very often times where we pay for very expensive medications because they're the best medication available, but if there's an equivalent medication that is not as expensive that will achieve the same therapeutic goal, then we will obviously opt for that medication first.

there any other considerations that factor into the UM determination of medical necessity that we haven't already talked about?

A Not that come to mind. I think we've covered most of those.

Q Does the prison's ability to provide postoperative care factor into the UM's determination of medical necessity?

A Generally, not. We try to accommodate most of those.

Q Are there circumstances where it does?

A I mean, I know there are circumstances where we have to consider that. So, for instance, if a procedure is out-of-state and we have to arrange custody support out of state. So, again, in the setting of prisons and having to ensure public safety, there can be times where we need to adjust to those accommodations to some degree.

Q Has DPS arranged surgeries out of state before?

A We have.

Q So looking at -- still on page 1 of Exhibit 4, the Utilization Management Policy, I want to look at -- under 2B, it states, "DOP utilization management staff use evidence-based clinical guidelines from nationally recognized authorities to guide utilization management

chemotherapy or radiation therapy, individuals that are getting physical therapy or occupational therapy. Those are more high-intensity services that require more frequent appointments and interventions.

Q I realize that I skipped when we were talking about the first sentence. What nationally recognized authorities does utilization management staff look to for its evidenced-based clinical guidelines?

A So, again, we've talked some about that. So it's relying on the individuals who have the expertise in that area. So depending on what condition you're looking at, you will consider their recommendations. Again, what I would say is that you have to do that in the context of prison. So we consider all of those things and evaluate all of those things, but we have to consider in the context of the prison setting.

Q So does that mean that utilization management does not utilize community consistent care?

A Absolutely not. So we have to treat the conditions, the same conditions the community treats. Precisely how they're treated and how they're addressed in prisons is going to vary to some degree. So, again, all of those professional organizations provide -- and, again, they call them guidelines for a reason, and we evaluate those guidelines accordingly.

Q So how does all of this inform medical necessity?

MR. RODRIGUEZ: Object to the form.

You can answer.

BY MS. MAFFETORE:

Q And I can clarify. How does severity of illness and intensity of service inform the decisions regarding medical necessity?

A So, again, I talked a little bit about that. So a severe illness, again, tips that risk-benefit scale in the direction of being medical necessary to prevent the things that I talked about, you know, death, severe disability, severe illness, so all of those things, and that's tips the scale dramatically in that direction.

Intensity of services is the same thing. So use the chemotherapy as an example. That is a highly intense service, but the risk of not performing that procedure is very significant to the individual patient were you not to proceed with that treatment. So that, again, tips the scale toward medical necessity.

Q So in terms of the evidence-based clinical guidelines, which organizations or sources does UM look to in developing those evidence-based clinical guidelines or reviewing those evidence-based clinical

guidelines?

A Really, any of them out there. It's going to depend on the condition you're treating. So if you're looking at an individual with diabetes, you'll obviously look to the Endocrine Society for what their recommendations are. If you're treating someone with heart disease, you'll look at the American Heart Association. So it's going to depend on the specific condition you're evaluating.

And, again, you look at those guidelines. You consider them. You consider them in the context of your clinical experience and in the context of prisons, and there you derive your conclusions, how you're going to proceed.

Q But as when we were discussing the Health and Wellness Services organizations policy, you would say that the folks on the utilization management board still look to those professional associations and organizations that we discussed previously that you stated were reliable?

MR. RODRIGUEZ: Object to the form.

You can answer.

THE WITNESS: They are the same ones I just mentioned. There is no distinction. So, yes, we do look to them. We do consider them, but they're not the

only consideration.

Q What about the American Medical Association?

A Sure.

Q The American Psychiatric Association?

A Yes.

Q And they do that even though their review is done in the context of prisons, as you said previously?

A Yes. All those agencies provide some guidelines to us, you know, some input into our consideration.

Q Given that you represented that UM does not provide community consistent care, are there other sources aside from those professional medical associations that we discussed that the UM would look to for guidance?

MR. RODRIGUEZ: I'm going to object to the form. You can answer.

THE WITNESS: You said the UM doesn't provide community consistent care?

BY MS. MAFFETORE:

Q Maybe we misunderstood each other. So earlier you told me that what utilization management does, they have to do within the context of prisons because in the prison setting, things are different than they would be in the community, and I have followed up to ask you the

the utilization review process works is the provider submits a request. The medical records tech enters that request, and it initially goes to the utilization review nurses.

There are some things that they have the authority to approve at their level. They can't defer anything at their level, but there are some things that they can automatically approve at their level. So that's what those guidelines talk about. What are those things that have the authority to automatically approve, and what are those things that they need to send utilization review for approval?

Q Okay. And are those written guidelines?

A They are.

Q Is there anything that would be provided for the treatment of gender dysphoria that a utilization review nurse has the authority to approve?

A No, and the reason for that is that in the case of gender dysphoria, the utilization review process, again, mirrors the utilization review process for everything else, but the utilization authority for gender dysphoria is the DTARC.

Q So did you just say the utilization review authority for the treatment of gender dysphoria is the DTARC?

it needs to be a DOT medication, direct observation therapy. So there are several examples where depending on the medication there may need to be some changes to how they are prescribed.

Q Are there specific conditions for which medication must always be approved through the physician review process?

A There is no conditions that I'm aware of. It's generally based on the medication itself.

Q Okay. Understood. Is there a difference in the approval process based on whether or not a condition is considered chronic versus acute?

A Not with the initial approval, but we do have what's called a MRTS system. So for a chronic condition, those medications are automatically refilled up to a period of time before that individual has a reevaluation.

Q Okay. How does DPS determine whether a condition is chronic?

A So we have designated what we consider to be chronic diseases or illnesses.

Q So those are designations that are standard and not specific to an individual?

A Correct. They're based on the condition.

Q Does DPS consider gender dysphoria chronic or

acute?

A It's a chronic condition, but not all transgender or gender dysphoric patients are on medications, obviously.

Q If somebody is on, for example, hormone therapy to treat their gender dysphoria, would that fall under the chronic and thus automatically renew, or would it -- or not?

A No. Because when you're treating someone for, in this case I assume for hormonal replacement, you need to monitor levels. So you don't want to automatically refill medications without checking the levels. So that will apply to a lot of conditions. Individuals that are on anticoagulants, if that anticoagulant requires surveillance, then that won't be an automatically refilled medication. It needs to be monitored accordingly.

Q So my understanding is if it's chronic, it's refilled automatically, but if it's not chronic, there essentially needs to be another UR in order for that person to continue on that medication if that's what's necessary?

A Generally, yes. Again, it depends on -- these are very medication-specific questions. So it's going to depend on whether there's -- thyroid's another

example. So if you're giving Synthroid to a patient, you need to monitor their TSH levels. So you don't want to just continue to refill that medication without monitoring that. So at each of those intervals, you'll need to enter a new prescription.

Q If DPS is unable to coordinate the monitoring that is necessary before a UR expires, does that medication continue in the interim?

MR. RODRIGUEZ: Objection to form.

You can answer.

THE WITNESS: So, again, that's going to be a clinical decision by the provider. So if a medication is about to run out and we haven't had labs or whatever surveillance is necessary performed, then that individual provider, the primary care provider, will need to make a decision, and it will be a risk-benefit analysis like we've talked about before, to determine whether we continue the current dose while we await those labs. If we hold the dose depending on the medication until we get the labs, if there's some clinical reason to believe that it's not an appropriate dose, then we can hold it. So, again, it's a very specific, individualized determination that's made.

BY MS. MAFFETORE:

Q If a UR for a specific medication has expired,

will a prisoner be able to receive that medication?

A Not once the order has expired, no.

Q Okay. So if a physician does not take some action on behalf of the prisoner before the UR expires, that prisoner just won't receive that medication while waiting for labs; is that right?

A I mean, theoretically that could happen. We also put some personal responsibility on the offenders as well to inform us that they need a refill of their medication. So there are fall backs.

Q If the medication is not a carry-on-person medication, how would the prisoner be able to tell whether or not their medication was about to expire?

A So they will know when their last prescription was, and they're informed what the duration of the prescription is when they receive the prescription. So they'll know they were prescribed 60 days, 90 days of their medication.

Q If somebody's given medication, it's not carry-on-person, they're given medication once every two weeks and it's administered to them and the UR order is for, for example, six months, is it still the responsibility of the offender to know when that prescription would expire and need to seek physician approval for a new prescription?

A I mean, it's certainly not the sole responsibility of the patient. I didn't mean that at all, but patients do have some personal responsibility in their healthcare.

Q So generally speaking, what are the steps for utilization review when a DPS provider prescribes a medical procedure?

A They're identical or at least parallel to what I just prescribed. So a medical procedure, they enter the order into HERO. The medical records tech transcribes that order from HERO into the UR system. It's routed to the utilization review nurses. If they have the ability to provide their level, which they generally are not going to for procedures, then they will refer that case to the review authority, so identical process.

Q Are the steps any different if the provider prescribes the medication or procedure is an outside contractor provider?

A So not many of our providers on the outside can enter orders directly into HERO. So many of them will provide a consult with a recommendation into our system. Then the primary care provider -- kind of like I referenced earlier, the primary care provider will review that, and if it's appropriate, then enter the

order into the system.

Q So just to make sure I understand, if, for example, DPS has referred a prisoner to an outside endocrinologist, for example, to manage their endocrinology needs and that is, therefore, the physician who would be prescribing any hormone therapy, the process would be that the endocrinologist's prescription is essentially treated by DPS as a recommendation, and then it's the primary care provider's responsibility for actually pushing through the request for that medication to be approved?

A That's correct.

Q Do the steps differ at all depending on the underlying condition that's being treated?

A No examples that I can think of.

Q What does it mean for a UR request to be pended?

A So generally that means that it's sent from the utilization review nurses to the review authority.

Q So it has been sent but has not been acted on?

A Correct.

Q What does it mean for a UR request to be deferred?

A So that is the examples that I cited earlier. So it could be that they sent it back to the provider

for additional studies, for additional evaluations, or they could have recommended additional treatments before they make the referral back again.

Q Are UR requests ever outright denied?

A No. "Deferred" is the term we use. If there were to be a circumstance where it's denied, it would be deferred.

Q So a deferral in certain circumstances is, in effect, a denial?

A Can be.

Q So same page that we were on, we're going backwards to B4. It states, "Not every specialist recommendation is necessarily appropriate. Circumstances such as specific diagnosis, patient condition, or expected duration of confinement in the correctional environment may influence the decision to proceed."

Did I read that correctly?

A Can you point me to where you are again? Oh. You read that correctly.

Q Okay. Under what circumstances does expected duration of confinement impact treatment decisions?

A So it, again, depends on the condition. So a good example would be hepatitis C treatment. If an individual is due to be released in two weeks and we

don't have time to initiate the appropriate therapy and follow-ups, then we will hold on that therapy until they're released, and we will work through our social workers to get that coordinated through the community.

Q If somebody needs care that could be administered and completed within the time left on their sentence, is the time remaining on their sentence a factor that's considered in the treatment decision?

MR. RODRIGUEZ: Object to vagueness.

But you can answer.

THE WITNESS: Yeah. So if I understand your question correctly, that if we are able to complete the entire treatment and the necessary postop follow-ups and other requirements -- in other words it's our responsibility to ensure that they are sufficiently taken care of after the procedure, as I mentioned, then the answer is yes, we'll proceed with that treatment.

BY MS. MAFFETORE:

Q Okay. So is it your testimony that there is no situation where DPS would deny a procedure on the basis of the time left in the sentence if there is sufficient time left in the sentence to administer the care?

MR. RODRIGUEZ: Object to form.

You can answer.

THE WITNESS: Yeah. I think I would need to know

the exact circumstances or examples of what you're describing, but generally we would proceed with that treatment.

Q So if based on the medical necessity criteria we've discussed, if based on the specific diagnosis, patient condition, or expected duration of confinement, the primary care physician agrees with an outside consultant about the recommendation, under what circumstances would UM defer recommendations set by the primary care physician?

MR. RODRIGUEZ: Object to form.

You can answer.

THE WITNESS: Again, I think I'd have to -- these are very scenario-specific questions so it's difficult to answer broad scale, but I think that certainly could be times where -- again, the review authority has that authority for a reason, and they can make those decisions based on specific clinical circumstances with that offender, the procedure that's pending, potential complications, the necessary postop follow-up or post procedural follow-up. All of those things are factors that would have to be considered.

BY MS. MAFFETORE:

Q So if an outside specialist in a field makes a recommendation based on that medical professional's

credentials and experience and referral to the relevant community and clinical standards and then the primary care physician does the same -- follows the same criteria and makes the same exact determination and these two physicians, one of which is a specialist and one of which treats a patient directly, they reach the same conclusion, the UM can, nonetheless, defer the recommended treatment?

MR. RODRIGUEZ: Object to form. Speculation.

You can answer.

THE WITNESS: Again, there's a lot of if's and presumptions in there, but --

BY MS. MAFFETORE:

Q Let's assume all of my if's and presumptions are true.

MR. RODRIGUEZ: Same objection.

You can answer.

THE WITNESS: Again, generally, those things are going to be approved. There can always be exceptions, though. I'd have to have a specific scenario to be able to give you a good opinion on that.

BY MS. MAFFETORE:

Q Can you think of any specific circumstances where it would not be?

A Not at the moment.

Q Are there any procedures that UM will defer in every instance, regardless of the specific circumstances of the individual?

A No. Even though things may be considered not medically necessary, there are always exceptions to that.

Q So it's your position that there is no medication or procedure that UM would automatically defer?

A No. Again, it's based on the individual patient and their clinical situation.

Q Are there procedures that UM would approve for one condition but would not approve for other conditions?

MR. RODRIGUEZ: Object to vagueness.

You can answer.

THE WITNESS: Again, I'd have to think about some specific examples. There's a multitude of possibilities. It's difficult to answer a hypothetical like that.

BY MS. MAFFETORE:

Q Can you explain the UR appeal process?

A Sure. Again, we talked about the process of getting to the UR approval authority. If that referral is deferred, then the submitting provider can then

BY MS. MAFFETORE:

Q So before the break, I read to you the definition from the policy Care and Treatment of Patient Disabilities, Exhibit 5, which read, "A physical disability is any physiological, mental, or cognitive disorder, condition or anatomical loss affecting one or more bodily functions, such as vision, hearing, speech, mobility, or manual dexterity."

Did I read that correctly?

A Yes, ma'am.

Q Based on this policy, is it DPS's position that a disability must affect a bodily function?

MR. RODRIGUEZ: Before you answer, I'd like to state several bases for an objection. One is it's a mischaracterization of what that previous sentence you just read mentions. Secondly, Dr. Campbell has not been appointed as a designee for the Department of Public Safety, currently known as of the Department of Adult Corrections, to speak to the department's policies and practices related to disabilities. The treatment of disabilities, how disabilities are determined, all manner of issues related to disabilities was not within the scope of one of his topics, and so he was not designated to speak as a designee for the department for that purpose.

And so with that objection noted on the record, you may answer to the extent you're able.

THE WITNESS: So I would say that everything within the body has a function, whether it be physical or mental. So in order to have a disability, there must be some impairment at some level of a function, whether that be a physical, an endocrinological, or a mental condition.

BY MS. MAFFETORE:

Q Are there psychological conditions that could rise to the level of disability under DPS's definition of disability as articulated in this policy?

MR. RODRIGUEZ: Before you answer, I'd like to incorporate by reference my most recent objection in full.

You can answer.

THE WITNESS: There could be.

BY MS. MAFFETORE:

Q What about anxiety?

MR. RODRIGUEZ: Before you answer, I'd like to incorporate my second to last objection in full.

You may answer.

THE WITNESS: So if it was so debilitating that it impaired function, whether social, occupational, then yes, theoretically it could.

Q What about depression?

MR. RODRIGUEZ: Same objection, fully incorporated by reference.

You can answer.

THE WITNESS: Again, if it impairs their ability in social, occupational avenues or other parameters, then yes, theoretically it could.

BY MS. MAFFETORE:

Q Could gender dysphoria be considered a disability under DPS's definition as articulated in this policy?

MR. RODRIGUEZ: Same objection, fully stated or incorporated as I previously stated.

You can answer.

THE WITNESS: Yes, ma'am, it could. Again, if it's so debilitating or causing such impact on either social or occupational or other parameters, then it could be.

MS. MAFFETORE: That's my full line of questioning as to this exhibit.

MR. RODRIGUEZ: I just want to make sure everybody's still awake.

BY MS. MAFFETORE:

Q So does the first policy that we discussed, which you, I think, described as the philosophy of the Department -- of the Department of Health and Wellness

Services organization policy, apply to considerations for gender affirming surgical care?

A Yes, ma'am. It applies to all healthcare.

Q Does the UM policy that we just discussed apply to considerations for gender affirming surgical care?

A Yes, ma'am. Same answer, it applies to all medical conditions.

Q And the care and treatment of patient disabilities policy we just discussed, does that apply to considerations for gender affirming care?

A Yes, ma'am. Same answer.

Q What does DPS consider to be community consistent care when delivering health services related to gender affirming surgery?

A Again, there is no difference from what we consider for any other condition. So we review and consider all appropriate entities and agencies and authorities that have provided evidence-based practices for the treatment of those conditions. We consider them and make decisions accordingly in the context of our setting, just like we do for any other medical condition. There is no distinction.

Q What community does DPS look to as a point of reference when it's considering community consistent care for gender affirming surgery?

A So there are a lot of them. There's the endocrinological society. Certainly we look at the WPATH guidelines as well and consider those. Again, we don't exclude any of those entities that could be -- you know, provide some valuable input into forming our decisions.

Q That's helpful, but not quite the question that I was getting after. So when we were talking about community consistent care previously, we were talking about, like, the geographic scope, and you said that some determinations might be state-based, but generally speaking, it was national. So what I'm asking here is what community, in terms of geographic scope, does DPS look to as a point of reference when considering community consistent care for gender affirming surgery?

MR. RODRIGUEZ: Object to form.

You can answer.

THE WITNESS: So, again, I would say that's all-encompassing. So the societies that I just mentioned don't specifically dictate anything based on a specific community. So all of those things are considered. We are in the state of North Carolina. So certainly what the accepted care within the state of North Carolina is another consideration. None of those are in and of themselves the sole determinant of our

decisions.

BY MS. MAFFETORE:

Q So would you say that DPS looks at state-based, nationwide, and in some circumstances even global guidance with respect to the treatment of gender dysphoria?

A Yes, ma'am. Not as much globally, obviously, but certainly it's a consideration.

Q So you did mention WPATH as one of the sources that you reference; correct?

A Correct.

Q Do you understand that to stand for World Professional Association of Transgender Health?

A Of course I do. They based out of the United States.

Q Do they have participants from other countries?

A Yes, they do, just like other endocrine societies and other medical societies do as well.

Q And so you also mentioned the Endocrine Society. Can you recall any other organizations or sources that DPS looks to for the treatment of gender dysphoria or the provision of gender affirming surgery?

A Sure. The American Psychiatric Society, the American Academy of Pediatrics, especially dealing with adolescents. So there's a lot of them.

Q Any others that you can recall?

A I'm sure there are others. I'd have to think on it, but not at the moment.

Q Okay. Has DPS identified an acceptable standard of care for the provision of gender affirming surgical care to treat gender dysphoria?

MR. RODRIGUEZ: I'm going to object to the form.

You can answer.

THE WITNESS: Say that one more time.

BY MS. MAFFETORE:

Q Has DPS identified an acceptable standard of care for the provision of gender affirming surgical care to treat gender dysphoria?

MR. RODRIGUEZ: Same objection.

You can answer.

THE WITNESS: No, but we haven't identified an acceptable standard of care for any conditions in the prison. Again, we based on the community standard, so.

BY MS. MAFFETORE:

Q Has DPS identified standards of care that are particularly useful for the provision of gender affirming surgical care to treat gender dysphoria in the prison context?

MR. RODRIGUEZ: Object. Ambiguity.

You can answer.

primary care provider would be notified of that, would enter the order. It would be approved, and it would be administered to the patient.

Q Okay. So the process then is request, DTARC -- so the primary care provider makes the request. It goes to DTARC, and then DTARC approves it. It goes back to the primary care provider that it's been approved, and then the primary care provider makes the request to utilization management, who then approves it and then sends that approval back to the physician to administer care?

A Not to the physician directly. In this case it would go to the pharmacy. They'd activate the prescription and send it to the facility. There would be nursing orders, and the nurse would administer the medication.

Q Okay. And in the case of a procedure, it would go back to not the treating physician?

A It always goes back to the treating physician. That is that offender's physician or provider.

Q Sorry. I will clarify. So if it is not, for example, hormone therapy, it is a procedure that is being requested, it would go -- the primary care physician would recommend the procedure. It would go to the DTARC. The DTARC would, in this hypothetical,

approve the procedure.

That procedure approval would go back to the physician. The physician would have to then re-request the procedure to utilization management, and then if utilization management approves that request, where does it go?

MR. RODRIGUEZ: I'm going to object to the form. You can answer.

THE WITNESS: I think I'm a little confused on the question, but it's the same process that we've covered with any other surgery. So it's the identical process where there's not gender affirming surgery. It's the exact same process that happens. It's just that instead of the UR review approval authority, it's the DTARC that acts as that approval.

BY MS. MAFFETORE:

Q But UM still has to approve? I thought that's what you just testified.

A Correct, but it's an automatic approval at that point.

Q It's an automatic --

A Correct.

Q So the UM no longer has discretion at that point?

A That's correct.

Q And based on your testimony, do I understand correctly that if DTARC has approved a medication or procedure, UM no longer has the ability to defer that as not medically necessary?

A That's correct.

Q Okay. And so if UM did that, that would be inappropriate under the policies that you just articulated?

A Yes, ma'am.

Q So just speaking a little bit more about how the general policies apply, specifically to the treatment of gender dysphoria, is it DPS's position that requests for gender-affirming surgery be considered on a case-by-case basis?

A Yes, ma'am.

Q And when considering the treatment of gender dysphoria, are clinical decisions the sole responsibility of managing health and wellness practitioners?

A Say that one more time.

MR. RODRIGUEZ: Object to the form.

BY MS. MAFFETORE:

Q Sure. So we were speaking earlier about the health and wellness policy, and we were speaking about a portion of that policy that stated "clinical

decisions are the sole responsibility of managing health and wellness practitioners." Do you recall our discussion about that?

A I do.

Q Okay. When considering the treatment of gender dysphoria, are clinical decisions the sole responsibility of managing health and wellness practitioners?

A Again, ultimately yes, but I will say this: With gender dysphoria, because of the nature of that condition, it is a multidisciplinary approach, and that's why we have a DTARC and why not an individual approval authority. So you've got to have input from multiple avenues, and when you say "treatment for gender dysphoria," there can be many things that are technically not clinical, especially in the prison setting, for instance.

So it can be simple accommodations, whether it's undergarments, whether it's cosmetics. Those type of things are technically not a clinical medical decision, but they do require input from other entities, particularly at the custody level. There are certain products or devices that are a security risk in those contexts I just described. So I think you have to exclude the things that are more purely medical,

meaning HRT and gender-affirming surgery from that whole category of gender dysphoria treatment, for lack of a better term.

Q Okay. So with respect to HRT and gender-affirming surgery, which you just categorized as clinical and medical, is the treatment of gender dysphoria -- are those clinical decisions with respect to hormone replacement therapy and gender-affirming surgery the sole responsibility of managing health and wellness practitioners?

MR. RODRIGUEZ: Object to the form.

You can answer.

THE WITNESS: So, again, it's the responsibility of the agency appointed committee, which is the DTARC collectively, to make that decision. The medical input is in these two circumstance, obviously, critical for that, but it's still a collective decision that's made by the committee.

BY MS. MAFFETORE:

Q So with regard to the clinical medical treatment of gender dysphoria, clinical decisions are not the sole responsibility of managing health and wellness practitioners?

MR. RODRIGUEZ: Object to the form.

You can answer.

surgeries.

BY MS. MAFFETORE:

Q Understood. So if somebody were to request a surgery that is not for the treatment of gender dysphoria, that would go to a utilization review; correct?

MR. RODRIGUEZ: Objection. Ambiguity as to somebody.

You can answer.

THE WITNESS: Correct. All surgical requests are routed that same way, regardless of whether it's related to gender dysphoria or not.

BY MS. MAFFETORE:

Q They would not go to a multidisciplinary committee; correct?

A Who wouldn't?

Q A surgical request for the treatment of something other than the treatment of gender dysphoria?

A No. There are specific reasons for that, and the reasons for that are pretty complex. So for instance, gender dysphoria is incredibly unique. It is the only condition that crosses disciplines.

So it's a psychiatric condition that carries with it potential surgical treatments as an option. There is no other psychiatric condition in the DSM-V

where surgery is an available option.

So the reason it has to be multidisciplinary is because in other cases of surgeries, the primary care provider is going to have the training and expertise to evaluate that particular offender for those particular conditions and make a recommendation. That primary care provider does not possess the training or expertise to deal with a condition such as gender dysphoria. Again, that crosses disciplines. So by definition has to be multidisciplinary evaluation for this particular condition.

Q So is it DPS's position that gender dysphoria is a psychiatric condition?

A It absolutely is. It's in the DSM-V.

Q And is it DPS's position that the individuals on the DTARC have the training and expertise to make decisions about gender-affirming surgery?

MR. RODRIGUEZ: Objection to form.

You can answer.

THE WITNESS: Yes, ma'am.

BY MS. MAFFETORE:

Q Okay. I was speaking with you about the process, and we can talk about justifications in a moment, but speaking about the process, if somebody requests gender-affirming surgery, it has to go to a

surgery is approved by a utilization reviewer, does it have to be approved by anyone else?

MR. RODRIGUEZ: Objection. Ambiguity. Vague.

THE WITNESS: Say that one more time.

BY MS. MAFFETORE:

Q If a surgery for the treatment of a condition other than gender dysphoria is approved by a utilization reviewer, does it have to be approved by anyone else at DPS?

A No. And in the case of gender dysphoria or gender-affirming surgery, that UR reviewer is the DTARC. So, again, same process, it's just different entities.

Q Right. And so after the DTARC approves a request for gender-affirming surgery, is there another step?

A Just the mechanical entry of that referral into the system.

Q So I would like to direct you to the third paragraph on page 7 of Exhibit 6, which reads, "All accommodation requests for surgical intervention or gender identity consistent facility transfer shall be reviewed by the Division TARC with recommendations referred to the assistant commissioner of prisons and director of Health and Wellness Services for review and

determination."

Did I read that correctly?

A You did.

Q Are there any -- so the policy then requires that after DTARC approves, there is another step for approval process; correct?

A Correct.

Q Okay. Are there any other surgical requests that have to be approved by the director of Health and Wellness Services and the assistant commissioner of prisons before they will be provided?

A Not that I'm aware of, but there are other surgeries that, for instance, will come to my level. Well, not just surgeries, but other interventions will come to my level where I'm essentially acting as this entity, as the director of health and wellness and now the deputy secretary.

Q And that is through the UR appeal process?

A No. That's through the UR. So, for instance, if we get a request for a prosthetic that's $300,000, then that's going to come to me for review. So there are instances where there is another level of review for procedures that -- the gender-affirming surgery is not the only case where that occurs.

Q Okay. But there are no other surgeries for

which the assistant commissioner of prisons makes a determination for an approval determination as to surgery; correct?

MR. RODRIGUEZ: Object. Mischaracterization of the document.

You can answer.

THE WITNESS: Again, it's analogous to the other example I gave. That review is required.

BY MS. MAFFETORE:

Q That review is required by the assistant commissioner of prisons?

A Correct.

Q For other conditions?

A No. For this condition.

Q So my question was, there are no other conditions for which surgical approval is required by the assistant commissioner of prisons; correct?

MR. RODRIGUEZ: Objection. Incomplete reference to the document.

You can answer.

BY MS. MAFFETORE:

Q Are there other conditions where the director of Health and Wellness Services has final review and approval process of a surgical request?

A Not that I'm aware of.

Q So just to be clear, there are no other surgical requests that need to be approved by the assistant commissioner of prisons and director of Health and Wellness Services other than for gender-affirming surgery for the treatment of gender dysphoria?

A Again, not that I'm aware of.

Q Okay. Thank you. Do you know whether there are any other conditions that DPS makes -- for which DPS uses a committee to make a medical necessity determination?

A I mean, there certainly are committees that make decisions, especially in the behavioral health realm. So there are committees that make competency decisions, all those type things, which is somewhat analogous, but again, what I would say is that this condition is unique because of the reasons I described, and that's why it requires a unique consideration.

Q Are there other conditions that DPS treats that require housing accommodations?

MR. RODRIGUEZ: Objection to form.

You can answer.

THE WITNESS: Sure. So if an individual has a wheelchair and has to have wheelchair-accessible rooms, if an offender has CPAP and needs to have a plug, if an

offender requires oxygen. So there are probably many, many more examples where housing accommodations are part of that process.

BY MS. MAFFETORE:

Q Are there any other conditions for which -- that DPS treats for which a patient might require a special type of clothing?

MR. RODRIGUEZ: Objection to form.

You can answer.

THE WITNESS: Dermatologic reasons comes to mind immediately. There could be a reason for an allergy-type condition or a hypersensitivity condition where certain clothing is required. Sun sensitivity, those individuals are often authorized clothing or garments that other offenders don't have. There's probably other examples as well.

BY MS. MAFFETORE:

Q Are there other conditions, the treatment of which would require special hygiene items?

MR. RODRIGUEZ: Objection. Form and assumption of facts.

You can answer.

THE WITNESS: None are coming to mind immediately. I mean, there certainly are hygiene items related to dermatologic conditions, again, that are required, but

other than that I can't think of any immediately.

BY MS. MAFFETORE:

Q Are there other conditions that DPS treats that present security concerns?

A Yes, ma'am.

Q Thank you. So it's 12:54. I've hit a natural breaking point. You said you wanted to stop around 1:00.

MR. RODRIGUEZ: That works.

MS. MAFFETORE: We'll go off the record.

(Recess.)

BY MS. MAFFETORE:

Q Back on the record. Dr. Campbell, welcome back. Just a reminder that after that prolonged break that you are still under oath, and we are still on the 30(b)(6) portion of your deposition. Before we move on to a new topic, I just wanted to circle back to the discussion we were having before the break regarding Dr. Junker and formally Mrs. Harris, now Ms. Buchholtz as reviewers.

A That's correct.

Q So the assistant commissioner of prisons and director of health and wellness services, as the final step reviewers for gender affirming surgery after the DTARC review, why did DPS select the assistant

commissioner of prisons and the director of Health and Wellness Services as the reviewers after the DTARC?

A So I think the reason for that is that they really are -- the best way to look at them is kind of an extension of the DTARC, for instance, and the reason that we chose Dr. Junker as the clinical representative and Assistant Commissioner Harris at the time, now Deputy Secretary Buchholtz, is that they can kind of represent both structures within the DTARC. So Dr. Junker can approach it from the clinical perspective, and the Deputy Secretary Assistant Commissioner can approach it from the custody perspective. So the facility transfers all those things that involve custody. So the best way to look at them is really -- they're really an extension of the DTARC.

So you've got a committee, which is unique, that has to look at this process, but you really need some kind of oversight of that entire process of that committee, and so they're really an extension of that DTARC.

Q Okay. Do you have any idea why it was decided that -- or why DPS decided that the assistant commissioner of prisons would be able to be a final decision maker specifically with request to gender-affirming surgery?

MR. RODRIGUEZ: Object to the form.

You can answer.

THE WITNESS: So, again, I think it's as an extension of the DTARC, it's analogous to the DTARC. Although, within the DTARC, those decisions are really going to fall on myself and behavioral health. The same thing applies at their level in that she is going to defer to Dr. Junker as a clinical representative at that level, and conversely Dr. Junker will refer to the assistant commissioner or deputy secretary for those specific custody-related things.

Because, again, it's important to remember there's a lot of things reviewed at the DTARC that are not just medical considerations, and so you've got to have a way to properly synchronize and filter and validate those things.

BY MS. MAFFETORE:

Q Okay. Moving on from that, I'm going to hand the court reporter what will be marked as Exhibit No. 7.

(Exhibit 7 marked for identification.)

BY MS. MAFFETORE:

Q Have you seen this document before?

A No, ma'am, not that I recall.

Q So I will represent to you that this is a

insurance coverages because in our context that's not what we're looking at.

Q So we discussed earlier that in making a medical-necessity determination, whether or not a majority of insurance providers cover the treatment would be a relevant consideration to the medical necessity of a treatment; correct?

MR. RODRIGUEZ: Objection. Slight mischaracterization of the witness's testimony.

THE WITNESS: Yeah. So, again, it's an associated portion of that evaluation. So it goes along with the standard of care determination, but there's a lot of other things that go into that. So it's just a factor, but certainly not -- you asked if this was a topic of discussion at the DTARC, and generally it's not a specific topic of discussion at the DTARC.

BY MS. MAFFETORE:

Q Has the DTARC ever approved a gender-affirming surgery as medically necessary for anyone in DPS's custody?

A Not that I'm aware of.

Q So I just want to be clear, speaking as DPS, has DPS ever approved a gender-affirming surgery as medically necessary?

A Not that I'm aware of.

Q Has any prisoner in DPS's custody ever received gender-affirming surgery?

MR. RODRIGUEZ: Asked and answered.

But you can't -- well.

THE WITNESS: While incarcerated?

BY MS. MAFFETORE:

Q While incarcerated.

MR. RODRIGUEZ: Asked and answered.

You can answer.

THE WITNESS: Not that I'm aware of.

BY MS. MAFFETORE:

Q What are the reasons why these requests have never been granted?

MR. RODRIGUEZ: Objection. Vague. Speculation.

You can answer.

THE WITNESS: Again, I'll go back to what I discussed, that for each of these cases there is an individualized review. There's specific cases and clinical circumstances in the context of that definition for medical necessity that we discussed, and that consideration, that risk-benefit analysis, that standard of care and that medicine review is part of every single one of those analyses.

BY MS. MAFFETORE:

Q So can you provide a summary list of reasons

A I guess I'm not clear. So you're saying what circumstances would make it medically necessary; is that what you're asking?

Q No. So the DTARC has considered at least 18 individuals' requests for gender-affirming surgery --

A I think it was 15.

Q At least 15 individuals' requests for gender-affirming surgery. I'm trying to get this top level so that we're not discussing any individual-specific circumstances, as I understand that that's an objection that your counsel has raised. So I'm trying to understand from you, what are -- you just said that certain circumstances are considered and weighed into a risk-benefit analysis, and then DTARC concludes that the surgery is not medically necessary.

What are the -- what are some of the circumstances that go into that risk-benefit analysis that have led the DTARC to conclude that these individuals do not require gender-affirming surgery and that it is not medically necessary or appropriate?

MR. RODRIGUEZ: Objection to form. Legal opinion. You can answer.

THE WITNESS: Okay. So probably the best way to answer that would be that as you do that analysis, and I guess I should step back a little bit and talk about

one of the principles that we look at in medicine. So in medicine there are stepwise treatments for any condition, step outside of gender dysphoria. In medicine when you do that risk-benefit analysis, you always opt for the least risky, least invasive procedure that meets your therapeutic objective.

So applying that to gender dysphoria, the therapeutic objective is to address their dysphoria. So at each of these points in time when they appear before the DTARC, we evaluate their current status of their gender dysphoria. That's the purpose of the DTARC.

So we get behavioral health assessments. We get mental health assessments. We get medical assessments, and we make an overall determination of is that individual stable. Are there indications that their gender dysphoria has not been adequately treated by the current or previous treatments? And if they are stable and doing well and there's no indication to step up that therapy, then oftentimes we will not step up that therapy.

So it's analogous to an orthopedic condition. If you come in to see your provider for knee pain, he's not going to immediately jump to surgery short of a catastrophic joint destruction. You're probably going

to get a nonsteroidal anti-inflammatory. You're going to get some rest, ice, heat, compression, elevation. You're going to get physical therapy. You may get an injection at the next stage, and eventually you may progress to surgery.

So, again, we should be consistent when we look at gender dysphoria, just like we are with every other medical condition we take care of. So at this point in time when these individuals appeared before the DTARC, their condition was satisfactorily controlled, again, met therapeutic objectives, and this next step was not indicated.

BY MS. MAFFETORE:

Q So I believe you just testified one of the things that you look to is whether or not the individual is stable, and if the individual is stable that would lead you to conclude that further intervention is not necessary; is that correct?

A May not be necessary, correct.

Q Okay. So if you could just look with me at Requester No. 7. The first entry related to Requester No. 7 in the DTARC recommendations column says, "Request not supported. Psychiatric instability."

So is it the case that instability would also in the DTARC's view and DPS's view counsel against

providing gender-affirming surgery for the treatment of gender dysphoria?

MR. RODRIGUEZ: Before you answer, I just want to make sure that your answer is not reflective of a particular case, but rather in the high-level sense of the question.

THE WITNESS: Yeah. So, again, without knowing exactly which case this is, what I can tell you is that very frequently, and this is true of not just with gender dysphoria, but patients often have concomitant illnesses, concomitant psychiatric illnesses. So very often what we see is an individual may be psychiatrically unstable for another condition, not for the gender dysphoria. And, again -- and that's -- even WPATH recommends that those conditions, those comorbid psychiatric conditions need to be sufficiently controlled and stable before you proceed with any treatments related to gender dysphoria. So that is certainly one way that that psychiatric instability does not necessarily mean that they're unstable from a gender dysphoria perspective by any means.

BY MS. MAFFETORE:

Q Okay. So if somebody is psychiatrically unstable, they can be denied gender-affirming surgery, but if somebody is a psychiatrically stable, that could

also be a reason to deny gender-affirming surgery for the treatment of gender dysphoria?

MR. RODRIGUEZ: Objection. Slight mischaracterization of the witness's testimony.

You can answer.

THE WITNESS: So, again, if they are psychiatrically stable for the gender dysphoria, that would indicate you don't need to proceed with treatment. If they're psychiatrically unstable from other conditions, you do not want to embark on treatment of their gender dysphoria until we stabilize those other conditions. So, again, many of these individuals have concomitant psychiatric illnesses that need to be addressed concurrently with their gender dysphoria.

Q Can gender dysphoria lead to concomitant psychiatric illness?

A I don't know that the research is completely clear on that. I think that there's probably research on both sides of that as to that association.

Q For several of these entries, all that is noted is, "request not supported, not medically necessary."

Do you see that?

A Yes, ma'am.

Q But there is no other indication in the DTARC

so.

Q Has DPS ever approved a request for a procedure that could be considered a gender-affirming surgery but for treatment of something other than gender dysphoria?

MR. RODRIGUEZ: Objection to form. Speculation.

You can answer.

THE WITNESS: So if I understand the question, there are many, many surgeries that are performed for completely medical indications that just also happen to be treatments for gender dysphoria. So there's a long list. A hysterectomy would be one, for instance.

BY MS. MAFFETORE:

Q Does DPS provide a hysterectomy for the treatment of conditions other than gender dysphoria?

A Yes, ma'am, when it's medically necessary.

Q What about mastectomy?

A When it's medically necessary.

Q What about gonadectomy?

A When it's medically necessary.

Q Okay. How does the medical necessity determination with respect to those other situations that you just detailed where, for example, hysterectomy might be necessary, how would the medical necessity determination differ there for treatment of gender dysphoria?

that particular condition in their clinical circumstances and make the determination that is medically necessary for that patient at that time.

Q So moving from the general to the specific, what was the process for considering Mrs. Zayre-Brown's request for surgery at the February 17, 2022, DTARC meeting?

A What was the process?

Q Yes.

A I'm assuming you're asking at the DTARC?

Q The February 17, 2022, DTARC meeting.

A Okay. So it's the same process that we use for every DTARC for every offender that's presented to the committee. So what happens is is that the case is initially presented. Dr. Peiper, as the chair of the committee, will present the case. They'll talk about, we are now evaluating offender X, incarcerated on this date, release date on this date, review of all of the previous FTARCs and DTARCs and those decisions that have been made up to that point, and then what is in front of the committee today for that individual, and then we proceed with the rest of the evaluations from each of the entities that sit on the DTARC.

So Dr. Peiper would generally give a mental health history or behavioral history. Dr. Sheitman

will give a mental health history. The PREA representative will talk about any concerns from that perspective. The custody or security will then provide their input into the case, any concerns. Programs will be involved and provide their input, and then medical also provides their input to the committee.

So we follow that same process every single time for every offender, and then there's discussion that follows after that to talk about what we want to do for that particular request for that particular offender.

Q So aside from your contribution on that day, did you serve any other role?

A Again, I am the medical authority on the DTARC. I also serve as a co-chair on the DTARC, but that's always my role.

Q So you served as co-chair on February 17, 2022?

A I did.

Q Okay. What comes along with the co-chair role?

A So, again, it's coordinating with Dr. Peiper to have the cases reviewed, presented to the committee, and then to provide my medical input.

Q Okay. What were the DTARC members expected to do to prepare in advance for this meeting?

A So we get the list of offenders that are going

to be presented, and the list includes, you know, what their previous FTARC -- the last FTARC date was, the previous FTARCs, and the issues that are in front of the committee for that particular offender for this upcoming committee meeting, and then each of us do our individual review of that case based on our individual perspective. So I'll review the medical history related to that, and each of them do their research up front so that they are prepared to present that to the committee.

Q So did each of the DTARC members review Mrs. Zayre-Brown's medical records in advance of that meeting?

A No. Many of them don't have access to the medical records. They're obviously protected. So custody officers don't have access to medical records. The programs folks generally don't have access to medical records. So it's the individuals that have a need to review those medical records will have access to those.

Q Who are the individuals who have the need to review those records?

A On the committee it's myself, Dr. Peiper, and that Dr. Sheitman.

Q So only you, Dr. Peiper, and Dr. Sheitman would

have reviewed Mrs. Zayre-Brown's medical records in advance of this meeting?

A Correct. I will make one caveat that the PREA representative is also able to review at least some of the medical record.

Q Would that have been Ms. Charlotte Williams?

A Yes.

Q Do you know if Ms. Charlotte Williams reviewed the medical records in advance of this DTARC meeting?

A I'm not sure.

Q Is there an expectation that those who have access to the medical records will review them to be prepared the DTARC meeting?

A There's an expectation that they review their perspective lanes for the DTARC. So in her case it's to review the pertinent aspects of her presentation at the committee.

Q And when we are speaking about medical records, do you interpret that term to be inclusive of mental health records?

A Yes, ma'am.

Q Okay. For the members of DTARC that have access to medical records, did the review of those medical records include records related to Mrs. Zayre-Brown's history of suicidal thoughts?

MR. RODRIGUEZ: Objection to form.

You can answer.

THE WITNESS: Yes. It's an all-inclusive. There's not a time period or any parameters. It's the entire medical record that's pertinent.

BY MS. MAFFETORE:

Q So then it also would have included her previous history of self-injury behavior?

MR. RODRIGUEZ: Objection to the characterization. The evidence is not before the witness.

You can answer.

THE WITNESS: Yes, ma'am, all medical records are included.

BY MS. MAFFETORE:

Q So you mentioned that the DTARC reaches consensus determination at the end of the meeting; is that correct?

A That's correct.

Q Prior to reaching that determination, is there a discussion among the members of DTARC?

A Yes, ma'am.

Q Okay. In the discussion regarding Mrs. Zayre-Brown on February 17, 2022, were there any disagreements?

A I really can't recall specific conversations

Q And just to clarify, all of these are as it relates to Mrs. Zayre-Brown's request, not the other 11 people considered that day. Did the DTARC discuss any reactions of staff to Kanautica potentially having surgery?

MR. RODRIGUEZ: Objection. Speculation.

You can answer.

THE WITNESS: I don't recall any discussions like that.

BY MS. MAFFETORE:

Q Was there any discussion at the February 17th meeting about the possible reactions of other prisoners if Kanautica were to receive surgery?

MR. RODRIGUEZ: Objection. Speculation. Vague.

You can answer.

THE WITNESS: Again, I don't recall that discussions really wouldn't be pertinent, so.

BY MS. MAFFETORE:

Q At the February 17, 2022, meeting of the DTARC, were there discussions about the benefits to Kanautica from obtaining surgery?

A I'm not sure what those would be, but I don't recall that.

Q I'm sorry. You don't --

A I don't know what you mean by "benefits," but I

don't recall a discussion.

Q Whether Mrs. Zayre-Brown would benefit in any way from the receipt of gender-affirming surgery.

MR. RODRIGUEZ: Objection. Vague.

You can answer.

THE WITNESS: I don't recall that specific discussion, no.

BY MS. MAFFETORE:

Q Were there any discussions by the DTARC on February 17, 2022, regarding the risks to Kanautica from not obtaining surgery?

A So, again, when you talk about the risk-benefit analysis, I routinely -- and I can't say that I did it in this specific case, but we routinely talk about both the risk and benefit from both sides, from proceeding and from not proceeding with the surgery. So that's routinely a consideration in all of these cases.

Q Did anybody voice a concern that without the surgery, Kanautica's gender dysphoria could worsen at the DTARC meeting on February 17, 2022?

A Again, I know we've talked about that in the general context, but I can't remember if we talked about it in her specific case.

Q What do you mean by the "general context"?

A Again, going back to the risk-benefit analysis,

there's always that potential, that not treating a condition can result in a worsening of that condition.

Q And was that discussed by the DTARC with respect specifically to Mrs. Zayre-Brown?

A Not that I recall specifically.

Q Has that ever been discussed by the DTARC with respect to specifically to Mrs. Zayre-Brown?

A Again, I can't recall a specific conversation, but it's routinely addressed with each one of these cases. It's hard for me to pinpoint from that particular -- for this particular offender.

Q How did DTARC arrive at the consensus of the February 17th meeting?

A So, again, as I discussed, everybody presented their portion of the case and their individual recommendations, and then there's a discussion. I'll tell you, it's probably the most collegial committee I've ever participated in. Everybody openly talks about what their impressions are, what their recommendations are, and there's discussion back and forth, and then there's a consensus that's reached. So it's a very frank and robust discussion.

Q But you can't, sitting here today, recall any of the opinions or recommendations that were discussed on February 17, 2022, with respect to Mrs. Zayre-Brown?

MR. RODRIGUEZ: Objection. Mischaracterization of the witness's testimony.

You can answer.

THE WITNESS: Again, to tell you specifically that that was discussed about her on that day as opposed to about her on another day, I cannot tell you with certainty that occurred on that day.

BY MS. MAFFETORE:

Q Did anybody from the DTARC express concern about denying her surgery on any other day?

A Not that I recall.

Q So you discussed with me, sort of, the discussion process, but I'm speaking specifically about the decision making, like getting down to the final decision to write on paper "gender-affirming surgery is not medically necessary, request denied." How did the DTARC arrive at that decision? By -- through what method?

A It's the method I've already described, that each prospective member of that committee discusses their particular points in the committee, and then there's a discussion. Because this was gender-affirming surgery, as we discussed before, very often it's going to be the medical individuals on that committee, it's their recommendation that's going to

carry the most weight.

Q So is it your impression that the nonmedical members of DTARC defer to the decision-making of the medical members of the DTARC?

MR. RODRIGUEZ: Objection. Mischaracterization of the witness's testimony.

You can answer.

THE WITNESS: Again, I don't know that they necessarily differ, but they are going to weigh their opinions very heavily. We, as physicians, are considered the authority on that committee related to this. So they're going to weigh that very heavily, just like if there's a custody-related concern, I'm going to weigh very heavily what security says. The same thing applies.

BY MS. MAFFETORE:

Q So when I'm asking you about the method of arriving at the decision, you keep mentioning to me the discussion process, and I understand that. I'm really just trying to understand how you ascertained that everybody is in agreement at the end of the day when you go to write that down. Do you go around the table and say, do you agree? Do you agree? Do you agree? Do you do a show of hands? Is there a vote? How did you determine that everybody was an agreement at the

A I don't remember that being a specific consideration.

Q So looking at the statement beginning on page 2 through the end of the document is a medical analysis. Who contributed to the medical analysis?

A I did.

Q Did anybody else contribute to the medical analysis?

A Not that I recall.

Q What aspects of Kanautica's individual medical history did DTARC consider in the medical analysis?

A So all aspects of her history. So, again, when -- as you read through this medical analysis, there are references to her stability, to her particular situation, the fact that she's continued to have follow-up, so.

Q Other than the final paragraph on page 5, can you point me to an area in the medical analysis that discusses Mrs. Zayre-Brown's specific medical situation?

MR. RODRIGUEZ: Object to the form.

You can answer.

THE WITNESS: Again, I think all of these certainly apply to Ms. Brown.

BY MS. MAFFETORE:

Q Do these paragraphs discuss her specific medical situation, is my question, her specific medical circumstances.

A I don't see her specific name referenced anywhere on these.

Q Okay. Are you familiar with Katherine Croft at UNC Health?

A Yes, ma'am.

Q Are you aware that Katherine Croft asserted with respect to Mrs. Zayre-Brown, "She likely does meet the requirements for medical necessity under gender dysphoria"?

MR. RODRIGUEZ: Objection. Speculation. Assuming facts that aren't before the witness.

You can answer.

THE WITNESS: She asserted that, you said, or inserted that?

BY MS. MAFFETORE:

Q Yes. Asserted.

A I don't remember if I saw that or not.

Q Okay. I'd like to hand the witness document DAC 4469, will which will be marked by the court reporter as Exhibit 11.

(Exhibit 11 marked for identification.)

BY MS. MAFFETORE:

Q Okay. How did Katherine Croft's assertion that Mrs. Zayre-Brown likely does meet requirements for medical necessity under gender dysphoria factor into DTARC's analysis?

A The first thing I'd point out is the word "likely," and the second concern I'd point out is that it's apparent from this that she has not even looked at her medical records. So, again, I have to consider that in the entire context. It's the person that says that they likely need it without having reviewed their records and without knowing their medical history carries very little weight, quite frankly, in these considerations.

Q Okay. Are you familiar with the endocrinology provider Dr. Caraccio?

A I'm familiar with the name, yes.

Q Are you aware of whether Dr. Caraccio has recommended gender-affirming surgery as medically necessary for Mrs. Zayre-Brown?

A I would have to look at his notes to say for sure, but what I can say is that I think that at some point he did make a referral or did recommend a referral for surgery, but I don't remember using the terminology that it's medically necessary.

Q Okay. I'm now handing the court reporter DAC

444 which we'll have marked as Exhibit 12.

(Exhibit 12 marked for identification.)

BY MS. MAFFETORE:

Q And I'll represent to you this is a clinical encounter note from provider Donald Caraccio. Does that appear correct to you?

A Yes, ma'am.

Q If you'll turn with me to the second page of this document, it will be DAC 445. If you look at the last paragraph under the assessment section, it reads, "Regarding her desire for vulvoplasty, this is medically necessary part of treatment for this patient. She has been treated with hormones since 2012 and orchiectomy in 2017 with persistent symptoms of gender dysphoria. Will communicate my plans with Dr. Figler."

Did I read that correctly?

A You did read that correctly.

Q Okay. How would the recommendation by Dr. Caraccio that gender-affirming surgery was medically necessary for Mrs. Zayre-Brown factor into the DTARC's consideration of Mrs. Zayre-Brown's request for surgery?

A Again, it is considered. What I would say is the simple statement that "persistent symptoms of gender dysphoria" is an inadequate explanation. There

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A You did read that correctly.

Q Okay. How would the recommendation by Dr. Caraccio that gender-affirming surgery was medically necessary for Mrs. Zayre-Brown factor into the DTARC's consideration of Mrs. Zayre-Brown's request for surgery?

A Again, it is considered. What I would say is the simple statement that "persistent symptoms of gender dysphoria" is an inadequate explanation. There

is no clarification on there to degree, severity, progression, how this has trended, what specific concerns they are as to why current treatment is not sufficient. So, again, it's a consideration along with several other considerations.

Q Did anybody ask Dr. Caraccio to elaborate further on his assertion that she had persistent symptoms of gender dysphoria and a medical necessity determination?

A I'm not aware.

Q Are you familiar with master's of clinical social worker Jennifer Dula?

A I am.

Q Are you aware of whether Ms. Dula ever indicated that gender-affirming surgery was medically necessary for Mrs. Zayre-Brown?

A I don't recall if she did.

Q I'd like to hand you what will be marked as Exhibit 13, which is DAC 686.

(Exhibit 13 marked for identification.)

BY MS. MAFFETORE:

Q Is this a document a transgender recommendation summary by provider Jennifer Dula dated October 20, 2021?

A Yes, ma'am.

Q This document has categories including review of mental health history, accommodation request, review of transfer gender history, adjustment to incarceration; correct?

A Correct.

Q Okay. And are you aware of Ms. Dula's role in treating Mrs. Zayre-Brown?

A I am. So she's a master's in social work.

Q So I'd like to direct you to the review of transgender history section.

A Okay.

Q It's the second paragraph. We'll go to the last two sentences of the first paragraph.

"She has been consistently on hormone therapy since 2012. Ms. Brown has also undergone several other gender affirming surgeries as part of her transition such as orchiectomy, breast augmentation, and facial feminization. Despite these interventions, Ms. Brown continues to report clinically significant anxiety, depression, and distress associated with her gender dysphoria that has been documented consistently throughout her mental health treatment.

"My clinical evaluation and the existing mental health documentation for Ms. Brown meets the criteria for diagnosis of gender dysphoria."

Did I read that correctly?

A You did.

Q Continuing to the third paragraph, "Based on the review of records and the current assessment, it appears the next appropriate step for Ms. Brown is to undergo trans-feminine bottom surgery. The surgery will help her make significant progress in the treatment of her gender dysphoria. Ms. Brown is psychologically stable to undergo the surgery and will be able to access postop care at an appropriate DPS facility.

"She has no issues with illicit drug use or abuse. Review of all medical consultations with UNC Trans Health show that the risks, benefits, and alternatives of surgery have been reviewed with Ms. Brown, and she showed excellent understanding during those consultations and this evaluation. She demonstrated the ability to make an informed decision about undertaking surgery. In summary, Ms. Brown has met the WPATH criteria and is an appropriate candidate for surgery?"

Did I read that correctly?

A You did.

Q How did the recommendation by Ms. Dula factor into the DTARC's analysis?

A So, again, it was also a consideration. Not taking anything away from Ms. Dula, but she is a master's in social work, coupled with this are assessments from psychiatry, psychology, multiple incidents of those evaluations by those higher-level providers. So, again, it's considered. It's important in context. Again, it's the trend that we want to see what these offenders. So, again, it's a consideration.

Q Are you aware of the outcome of the surgical consult with Dr. Figler with regard to Mrs. Zayre-Brown's request for gender-affirming surgery?

MR. RODRIGUEZ: Objection. Vague.

You can answer.

THE WITNESS: I'm aware that she saw Dr. Figler, yes.

BY MS. MAFFETORE:

Q What did Dr. Figler conclude?

A If I'm not mistaken, he simply concluded that she met the minimum WPATH criteria for surgery, but if I recall correctly, he also did not provide any justification for that, no explanation of why he felt that was indicated. To my knowledge, he can't even review the records to be able to tell whether she was psychiatrically stable or not. So, again, I think from what I understand, it was simply saying that she met

minimum WPATH criteria for surgery.

Q Did anybody follow up with Dr. Figler to seek additional justification from him regarding his assertion that she met the WPATH criteria for surgery?

A I'm not aware.

Q How did the surgical consult with Dr. Figler factor into the DTARC's analysis?

A Again, it was also a factor.

Q So these four providers who have seen Mrs. Zayre-Brown in person and evaluated her all confirmed that she was a candidate for surgery. What led DTARC to conclude that Mrs. Zayre-Brown was not an appropriate candidate for surgery?

MR. RODRIGUEZ: Objection. Mischaracterization of the previous testimony.

THE WITNESS: So I guess I'll start by saying that before you were referencing, I assume, Ms. Katherine Croft, who is one of those who is not a provider, who simply runs the trans health medicine program, transgender health program. I'm not sure who the other -- you've got Dr. Caraccio, the endocrinologist, Ms. Dula, and who was the last one?

BY MS. MAFFETORE:

Q Dr. Figler.

A Dr. Figler. So, again, all of those are

considered. Again, the same thing I referenced before is that their opinions are important. They are considered, but we look at the entire picture in the context of prisons and in this case how Ms. Brown had responded to the accommodations that had already been provided and whether or not her condition had progressed significantly enough to give us an indication that current treatments were not sufficient.

Q So you mentioned that there were higher-level individuals than Ms. Dula who had rendered some kind of clinical evaluation of Mrs. Zayre-Brown. Who were those higher-level individuals that rendered those decisions?

A So I know she was seen by multiple psychiatrists and psychologists over her time in prison.

Q Did any of them conclude that gender-affirming surgery was not medically necessary to treat her gender dysphoria?

A That was not a clinical question they were asked. So they were providing care for her.

Q Were any of the higher-level individuals who treated Mrs. Zayre-Brown asked by the DTARC whether or not Mrs. Zayre-Brown required gender-affirming surgery for the treatment of her gender dysphoria?

A I don't know if they were specifically asked that question, no.

Q Were they consulted regarding the decision to deny Mrs. Zayre-Brown gender-affirming surgery?

MR. RODRIGUEZ: Objection to form.

You can answer.

THE WITNESS: There's not that type of consultative process that occurs. So their clinical documentation is what we review. We review everyone's clinical documentation related to, in this case, Mrs. Zayre-Brown as she presented to the committee, and we make a collective decision on her stability and whether or not her condition had progressed to the point that we felt that the next step in treating was indicated.

BY MS. MAFFETORE:

Q So DTARC did not consider other mental health professionals that had treated Mrs. Zayre-Brown's professional opinions as to whether gender-affirming surgery was medically necessary?

MR. RODRIGUEZ: Objection. Mischaracterization of the witness's testimony.

THE WITNESS: No. I already stated we considered it.

BY MS. MAFFETORE:

Q Did any of the higher-level professionals

MR. RODRIGUEZ: Objection to form.

You can answer.

THE WITNESS: So the transgender accommodation summary, if this was the time that she appeared before the FTARC and then the DTARC, this is presented and was presented to the DTARC after the FTARC. My point is that the DTARC also considers the clinical notes from this point in time till the committee met.

BY MS. MAFFETORE:

Q Did Jennifer Dula at some point subsequent to October 20, 2021, conclude that Kanautica was no longer experiencing clinically significant distress or anxiety or depression related to her gender dysphoria?

A I would have to review the records to say whether she made any additional recommendations.

Q Can you point with specificity to any other provider who made findings to say that Kanautica was no longer experiencing clinically significant distress?

MR. RODRIGUEZ: Objection to form. Speculation.

You can answer.

(Simultaneous speakers.)

THE REPORTER: One at a time, please.

THE WITNESS: I'd have to review the records.

BY MS. MAFFETORE:

Q Okay. Is there anything that you can point to

with specificity that shows that the candidate was no longer experiencing clinically significant anxiety, depression, or distress related to her gender dysphoria after October 20, 2021?

A So there was a lot occurring during this time frame in advance of her getting to that DTARC in February, and again, you asked previously about whether we had reviewed some of the other incidents from a year or so prior to this event, and we had.

So, again, what we looked at is the trend and how she had responded, and I do remember specifically that at the DTARC it was made very clear based off the assessments from Dr. Peiper and Dr. Sheitman that she was remarkably resilient. She had responded very well.

She had adapted very well to changes, and it was in August that she had just -- I think it was August she had moved -- if I recall correctly, she had responded very well, and they presented to the committee that she was stable and in her current status, and that's the recommendation that came from both Dr. Peiper and Dr. Sheitman at the DTARC.

Q Did Dr. Peiper have a clinical encounter for evaluation with Mrs. Zayre-Brown leading up to the DTARC to evaluate her circumstances?

A I'm not aware.

Q Did Dr. Sheitman?

A I'm also not aware.

Q Did Dr. Peiper conclude that she no longer had clinically significant distress related to her gender dysphoria?

MR. RODRIGUEZ: Objection to form.

You can answer.

THE WITNESS: Not using those exact words, but certainly Dr. Peiper did conclude that she was stable and that there was no indication of worsening illness. So that's essentially what that means.

BY MS. MAFFETORE:

Q Can somebody be stable but in critical condition?

MR. RODRIGUEZ: Objection. Form.

You can answer.

THE WITNESS: Stable and critical condition?

BY MS. MAFFETORE:

Q Can somebody maintain the same level, a stable level of bad?

MR. RODRIGUEZ: Objection to form.

BY MS. MAFFETORE:

Q Does stable imply good?

A No, it does not.

Q Okay. That was my question. Can somebody be

stable but still be depressed?

A Yes.

Q Can somebody be at a stable level of distress?

A Yes.

Q By Dr. Peiper saying that Mrs. Zayre-Brown was stable, that does not necessarily indicate that she was no longer experiencing a clinical level of distress related to her gender dysphoria; correct?

MR. RODRIGUEZ: Mischaracterizing as to what Dr. Peiper said.

THE WITNESS: So I think I understand your question. I think that the -- in this case there was more than just the stable. You keep honing in on the stable, but you left out the well adapted, you know, all of those things that are clarifiers of that stability, that made that stability more than just --

I understand your point. Stable, you can have no vital signs. They're still stable; right? But that's not the point. The point is that there were clarifiers that he added to that.

BY MS. MAFFETORE:

Q Is there any other medical condition where an individual's resiliency or adaptability would make it unnecessary for them to receive care in order to address their underlying condition?

MR. RODRIGUEZ: Objection. Speculation.

You can answer.

THE WITNESS: I think that's a mischaracterization of what I said. So individuals can have medical conditions that are, we'll use the term "stable," but that doesn't mean that you need to intervene.

So what I would say is that what you want to see, I referenced it before, is that you want to see that that individual -- resiliency is commonplace in prisons or commonplace in medicine, you know. It doesn't just refer to gender dysphoria, and it's particularly important when it comes to behavioral health conditions that they're resilient because that's where the biggest impact of that is. So I think you mischaracterized what I said.

Q I didn't characterize what you said. I asked you a question. If somebody requires a medical intervention, how does the fact that they are a resilient person factor into their need for medical care?

MR. RODRIGUEZ: Objection. Assumption of facts.

You can answer.

THE WITNESS: Again, it's a hypothetical. I'm not sure I understand the question.

BY MS. MAFFETORE:

she wanted to undergo.

Q And your understanding -- is it your understanding that was before the DTARC meeting or afterward?

A I know it was definitely before that she changed. So with her consultation with Dr. Figler, I think, if I recall correctly, once Dr. Figler explained the procedure and the potential complications and postop recovery, at the conclusion of his note, if I recall correctly, he said that she had opted to go forward with vulvoplasty as opposed to vaginoplasty.

Q Are you aware that it's changed since then?

A I'm not aware.

Q Okay. And I asked you a very specific question before that was maybe a little too specific so I'd like to ask you a slightly more general version of that question.

Was DPS aware of whether Mrs. Zayre-Brown was suffering from clinically significant distress associated with her gender dysphoria around the time of the February 17, 2022, DTARC meeting?

A Were we aware of whether she was or not?

Q Yes.

A That is the underlying question always when you're evaluating gender dysphoria cases before the

DTARC because that is the requirement, that it's necessary for the diagnosis and also to measure clinical stability. You know, what I'll say is that -- I know I keep going back to this, but if you were to go back exactly a year before this DTARC that -- where we were considering her for this case you're asking me about, that's the point where -- you referenced those earlier -- where she had done some things that were genital-mutilation type activities or efforts, and so at that point we could consider that that was -- at that point was a peak of her gender dysphoria, the severity of her gender dysphoria --

Q So what I'm asking is, what are you aware of about her condition of clinically significant distress around the time of the DTARC meeting in February of 2022? What was DPS aware of regarding her clinically significant -- her clinically significant distress at that time?

A So we were aware of what was presented to the DTARC from both Dr. Peiper and Dr. Sheitman regarding her current condition and how well she's adapted -- her clinical status, her stability, and how well she's adapted to the facility.

Q Okay. Around the time of February 17, 2022's, DTARC meeting, was Mrs. Zayre-Brown experiencing

clinically significant distress as a result of her gender dysphoria?

MR. RODRIGUEZ: Objection. Vague.

You can answer.

THE WITNESS: It was not relayed to us at the DTARC that it was severe enough to warrant proceeding with surgery.

BY MS. MAFFETORE:

Q Regardless of severity, was she experiencing clinically significant distress around the time of the DTARC meeting as a result of her gender dysphoria?

MR. RODRIGUEZ: Objection to form.

You can answer.

THE WITNESS: I don't recall any specific note saying that she was.

BY MS. MAFFETORE:

Q Do you recall any specific note saying that she was not?

A Again, what I discussed is the assessment from our chief of psychiatry and chief of behavioral health.

Q And I believe you testified previously that neither of them stated that she was not suffering from clinically significant distress as a result of her gender dysphoria; is that correct?

A I don't know that's what I said, but what I do

know is what they presented to the committee was the same thing I've mentioned before, is that there were no indication of worsening of her condition.

Q We can move on. So regarding the case summary, which was Exhibit 8, a comprehensive literature review is mentioned. Who engaged in that comprehensive literature review?

A So if you're referencing a medical analysis, that would be my literature review.

Q Okay. And what sources were considered?

A All sources. So as I started looking -- as I started evaluating medical necessity in the context of gender dysphoria, I initially started with the references, which are listed in WPATH. So at the time -- I think this was a still on the seventh version. I subsequently did the same thing with the eighth version.

So I initially started the literature review looking at those sources. I didn't review every single source. There's quite an extensive list in there, but as I read through the standards of care and there was a particular recommendation that was of concern, I would then review the literature associated with that.

From there what I did is, you can often when you review other studies, you can then branch out to --

because some studies will reference previous studies. So I started expanding that out to other studies as well, and that's the way we generally do literature reviews. You start with a baseline, and you kind of branch out, and so all sources were considered.

Q Okay. Did anyone on the DTARC have any discussions with Dr. Junker before rendering its decision regarding medical necessity?

A I don't know if other people had discussions with Dr. Junker or not. I don't recall any discussions with him.

Q Did anybody -- did anybody have discussions with Brandeshawn Harris?

A Not to my knowledge.

Q Okay. Can you describe the approval process by Dr. Junker and Ms. Harris after DTARC informed them of the recommendation as to Mrs. Zayre-Brown as a result of the February 17, 2022, DTARC?

MR. RODRIGUEZ: Objection. Speculation as to things said or exchanges between Harris and Junker of which Dr. Campbell cannot be aware of.

You can answer.

BY MS. MAFFETORE:

Q As DPS, can you please describe the approval process by Dr. Junker and Brandeshawn Harris after the

that they might have had with respect to that request?

MR. RODRIGUEZ: Objection. Speculation.

You can answer.

MS. MAFFETORE: Speculation as to if he's aware?

MR. RODRIGUEZ: If he's aware that two people met which he was not involved in, yeah. You're asking about a meeting between two people that aren't him.

BY MS. MAFFETORE:

Q So the case summary ultimately concluded, "Having taken all of these factors into consideration, it remains my medical determination that the surgical procedure requested by this offender is not medically necessary"; correct?

A Correct.

Q Okay. And the "my" there, is that you?

A It is.

Q Okay. If a procedure would significantly decrease the likelihood of a patient committing suicide, would that make it necessary?

MR. RODRIGUEZ: Objection to form.

You can answer.

THE WITNESS: That's a purely hypothetical. To my knowledge, there is not definitive evidence that any procedure will prevent suicide.

BY MS. MAFFETORE:

Q I didn't say "prevent." I said "decrease the likelihood."

A Same answer. I'm not sure there's any procedure that's going to decrease the likelihood of suicide.

Q If a procedure would prevent significant mental health disability, would that make it necessary?

A Again, that's a hypothetical. I'd have to have an example.

Q Are you aware of any procedures that can prevent significant mental health disability?

A Procedures? I guess you'd have to define "procedures."

Q Non-drug based treatment.

A There aren't any that I'm aware of.

Q What about electroshock therapy?

A Used very seldom, very rarely these days, very discreet circumstances.

Q In discreet circumstances, is it used to prevent significant mental health disability?

MR. RODRIGUEZ: Objection. Speculation and outside of the scope of the 30(b)(6) topics.

THE WITNESS: It is certainly practiced in very specialized centers on occasion, is all I can say. It is not a common practice by any stretch of the

Q Okay. So you believe that you began drafting this around January of 2021?

A Correct.

Q And that was before the DTARC considered Mrs. Zayre-Brown's request for surgery; correct?

A Her requests for surgery's been considered previously, so.

Q Before her February 17, 2022, DTARC meeting that we were just discussing?

A That's correct.

Q Okay. And did anyone direct you to draft this document?

A No, and that's a part of what I was trying to answer is that this was something that I did independently as the chief medical officer to assist with utilization review across the board to simply apply those standards, those tenets that I came up with, in this context to assist in this case a utilization review authority, which is the DTARC. The same thing was going to be applied to the utilization review process across the board within DPS.

Q Did anybody else within DPS provide comment on this summary -- this position statement?

A At some point it was presented to the DTARC for their review, yes.

Q Did you receive comments on it?

A Yes. So this was a discussion that occurred with the DTARC.

Q Did you receive comments on it?

A I did.

Q What comments did you receive?

A Again, from the DTARC members, they provided their input to me. I don't remember specific input. I think that, again, most people felt that this was within my purview as the chief medical officer and as the medical authority on the DTARC. So they reviewed it, and we had a discussion about it, but I don't remember any specific comments.

Q Okay. I'm not asking for specific comments. What general feedback did you receive with regard to this position statement?

MR. RODRIGUEZ: Asked and answered.

You can answer.

THE WITNESS: Same thing I stated before, that they reviewed it. They deferred to me as the medical authority on the DTARC.

BY MS. MAFFETORE:

Q Did anybody outside of the DTARC provide you any input regarding this position statement?

MR. RODRIGUEZ: Asked and answered.

You can answer.

THE WITNESS: Not that I recall.

BY MS. MAFFETORE:

Q What about Dr. Peiper?

MR. RODRIGUEZ: Asked and answered.

You can answer.

THE WITNESS: Dr. Peiper is on the DTARC.

BY MS. MAFFETORE:

Q Did Dr. Peiper provide you any feedback, either within the confines of the DTARC meeting or externally to the DTARC process, regarding this position statement?

A He may have. I don't recall specifically.

Q Did anybody express disagreement with the position statement?

A I don't remember any specific disagreement. I think, again, there was discussion, and I had to explain to them the same thing that I'll tell you, that this was not meant to be a blanket ban on surgery. This was simply to provide some guidelines so that the committee could review gender-affirming surgery objectively as we looked at these cases.

So I think that there was some concerns raised that we wanted to make sure that was not how this was presented, and I pointed out to them that that was

never meant to be the case. This was never meant to be a DPS policy. This was simply guidance being provided to the DTARC in their capacity as the utilization review authority.

Q So you just stated that this was not meant to be a blanket ban on surgery, but it was supposed to allow for consideration of these requests in an objective way; am I understanding you correctly?

A Correct.

Q So page 2 of this document, the second paragraph states, "After extensive and objective review and analysis of hundreds of studies and other publications, it has been determined that gender-reassignment surgery, GRS, as a treatment for gender dysphoria is not medically necessary."

Did I read that correctly?

A You did.

Q Okay. So I understand that you just said that this was not intended to be a blanket ban but was supposed to be considered for an objective determination of surgical requests. If the position that was expressed that that should be relied on objectively, as you've indicated, is that gender-reassignment surgery is not medically necessary in any circumstance, what could -- what outcome would

result other than denial of gender-affirming surgery following consultation of this position statement?

MR. RODRIGUEZ: Object to form.

You can answer.

THE WITNESS: So I did not say "under any circumstances," and that's specifically intentional that there are many procedures which are considered not medically necessary, surgery procedures in particular. However, there are always exceptions to that, and we don't always list all those exceptions. So for instance, a lipoma on an individual's skin is not medically necessary for incision unless -- and there can be various factors. It can be over a joint. It can be impacting other organs. It can be impairing function. So in that case that tips that over into being medically necessary.

In the prison circumcision is not medically necessary. However, there are circumstances where circumcision will be conducted. So if an individual has phimosis, paraphimosis, all of those symptoms, then that procedure, which is generally not medically necessary, becomes medically necessary.

Inguinal hernias are generally not medically necessary for surgery. However, if they're incarcerated, they become medically necessary.

So, again, I could go on and on and on and list examples, but I specifically did not say "under any circumstances," and that was never the intent of this document.

BY MS. MAFFETORE:

Q So then what is meant by "gender-reassignment surgery as a treatment for gender dysphoria is not medically necessary"?

A It goes back to what I just stated, that generally those things are not -- surgery is not required for particular procedures, just like surgery's generally not required in this context unless the individual, through that risk-benefit analysis, through that individualized review, demonstrates significant disease that's not being adequately addressed with current treatment therapies. So the same thing is analogous to those other conditions that I just told you about.

Q So you mentioned that there was concern expressed that this was considered or going to be perceived as a blanket ban on gender affirming surgery. Who expressed that concern?

A I don't recall exactly. I know that -- Dr. Peiper may have mentioned that, but I can't be certain, but I know that that was brought up as how this could

A Say that one more time.

Q Was the DTARC aware of the rationale included in this draft position statement at the time that it was considering Mrs. Zayre-Brown's request for gender-affirming surgery during February of 2022?

MR. RODRIGUEZ: Objection. Vague as to rationale.

You can answer.

THE WITNESS: Certainly we had discussed aspects of this in the DTARC as part of my medical recommendation. So, yes.

BY MS. MAFFETORE:

Q Did any aspects of the position statement inform the case summary that you provided for Mrs. Zayre-Brown?

A It did.

Q Was there any further discussion within DPS about this position statement after you sent this email but before a vote was taken?

A I don't recall. I don't even recall whether the voting ever occurred. I'm not sure if that voting ever even occurred.

Q Is there a way that you can determine whether the voting ever occurred?

A I don't know. I tried looking at my emails to see if there were anything, and I certainly can't find

COUNTY OF ORANGE

CERTIFICATE OF REPORTER

I, SUSAN L. GALLAGHER, CA CSR, CVR-CM, Notary Public do hereby certify that ARTHUR CAMPBELL, M.D., was duly sworn by me prior to the taking of the foregoing deposition, that said deposition was taken and transcribed under my supervision and direction; that the parties were present as stated; and that I am not of counsel for or in the employment of any of the parties to this action, nor am I financially or otherwise interested in the outcome of this action.

I do further certify that the foregoing 217 pages constitute a true and accurate transcript of the testimony, and that the witness is being given 30 days in which to affix his notarized signature to the testimony.

This the 2nd day of May, 2023.

_____

SUSAN L. GALLAGHER, CA CSR, CVR-CM

Notary Public #20230500301

WITNESS CERTIFICATION

I, ARTHUR CAMPBELL, M.D., hereby certify:

That I have read and examined the contents of the foregoing testimony as given by me on April 17, 2023, and that to the best of my knowledge and belief the foregoing pages are a complete and accurate record of the testimony given by me, except as noted on the attached Addendum A hereto.

I have __ have not __ made changes/corrections.

_____

ARTHUR CAMPBELL, M.D.

I,_____, Notary Public for the County of _____, State of _____, hereby certify that the herein above-named appeared before me this the _____ day of _____, _____; and that I personally witnessed the execution of this document for the intents and purposes as herein above described.

_____

Notary Public

(SEAL)

My Notary Seal Expires:

_____

DEPARTMENT OF PUBLIC SAFETY
PREVENT. PROTECT. PREPARE.

PRISONS
Health and Wellness Services
Policies and Procedures

Title	Health and Wellness Services Organization			
Section	AD I - 8	Issue Date December 22, 2020	Supersedes Date New	Next Review Date December 2021

References

Performance-Based Standards and Expected Practices for Adult Correctional Institutions, 5th Edition 5-ACI-6A-04, 5-ACI-6A-05, 5-ACI-6A-18(M), 5-ACI-6A-27, 5-ACI-6A-43(M), 5-ACI-6B-01(M), 5-ACI-6B-02(M), 5-ACI-6B-04, 5-ACI-6C-01, 5-ACI-6D-01, 5-ACI-6D-02(M), 5-ACI-6D-04, 5-ACI-6D-08, 5-ACI-6D-09, 5-ACI-6D-10

I. PURPOSE

Identify North Carolina Department of Public Safety (NCDPS), Division of Prisons (DOP) Health and Wellness Organization.

II. SCOPE

(a) Health and Wellness Services are approved by the Director of Health and Wellness in consultation with Health and Wellness Clinical Leadership and DOP Management.

(b) Health and Wellness Core Values align with DOP's **PRIDE**:

(1) Protect

(2) Respect

(3) Integrity and Innovation

(4) Duty and Diversity

(5) Excellence

(c) In support of DOP's Mission Statement, Health and Wellness professionals shall promote excellence, provide community consistent, cost effective, quality healthcare throughout our system.

(d) Health and Wellness professionals are committed to DOP's Vision Statement to build a premier correctional health and wellness program.

(e) Health and Wellness Leadership provides consultation, training, education, expertise, data, and information to Health and Wellness personnel, Facility Leadership, DOP and NCDPS Leaderships.

(f) The constitutional obligation, grounded in the Eighth Amendment, and statutory requirement in North Carolina General Statute 148-19 requires Health and Wellness to provide offenders access to quality care provided by competent healthcare professionals.

(g) Goals and objectives are reviewed at least annually and as needed. Our goals are to:

(1) View correctional facilities as public health stations that significantly impact the health status of the larger community;

(2) Provide care that will positively impact the public health sector;

(3) Improve the health status of the offender;

(4) Obtain/yield the highest value for the total tax dollars spent;

(5) Engage in sound healthcare practices that meet an acceptable standard of care;

(6) Ensure consistency with the mission and goals of the North Carolina Department of Public Safety/Division of Prisons/Health and Wellness.

(h) Provision of Treatment regarding clinical decisions that involve Health and Wellness providers are the sole responsibility of the managing Health and Wellness practitioner and are not reversed by non-clinicians.

(i) Periodic Examinations for offenders:

(1) Under 50 years of age shall be scheduled every 5 years or as clinically indicated.

(2) Over 50 years of age with Chronic Care diagnosis shall be scheduled annually or as clinically indicated.

(i) Health and Wellness personnel provide for the care, treatment and services for Safekeepers/Pre-Trial Detainees, received from the jail system for health and wellness or security reasons in accordance with a court order.

(j) Grievances received at Health and Wellness Central Office relating to Health and Wellness services are addressed by the Family Liaison.

III. SERVICES AND RESPONSIBILITIES

(a) Ancillary Services, such as Laboratory and Radiology, may be provided on-site at facilities or acquired under contractual agreements with vendors.

(b) Behavioral Health Services is approved by and the responsibility of the Director of Behavioral Health. Services are available to offenders identified with a serious mental illness and those with less severe mental health needs related to emotional, cognitive and behavioral deficits.

(c) Communicable Disease and Infection Control Services decreases the spread of communicable diseases and infection control through surveillance, treatment and education.

(d) Dental Services provides medically necessary dental care to offenders. The Dental Director is responsible to develop, implement and monitor dental care in accordance with North Carolina State Board of Dental Examiners and applicable statutes, rules and regulations. Medically necessary dental care is available to all offenders.

(e) Director of Health and Wellness as the Health Authority (unless otherwise designated by the Commissioner of Prisons) is responsible to plan, organize, and coordinate a Health and Wellness delivery system which includes medical, nursing, dental, behavioral health, mental health, pharmacy, quality assurance and administration for all offenders incarcerated within NCDPS, DOP.

(1) Provides consultation to Facility, DOP, NCDPS management staff, NC Legislators, NC State Agencies and Community colleagues regarding health and wellness services.

(2) Appoints Health and Wellness personnel, based on subject matter, to write, review or revise Health and Wellness policies and directives. Policies and directives are reviewed annually and as needed.

(3) Directives must be approved by the Director of Health and Wellness after review by the specific discipline/section lead.

(f) Facility Health Authority may be a physician, physician extender or nurse designated by the Facility Warden who has the responsibility for Health and Wellness services in accordance with a job description or written contract.

(1) If the Health Authority is not a physician, final clinical judgements rests with a single designated physician.

(2) Create a facility mission statement that describes the extent of health and wellness services provided.

(4) Develop and implement a facility staffing plan from data collected from the annual (or as needed) staffing analysis that determines the disciplines of Health and Wellness staff required to provide the identified facility's scope of services.

(5) Responsible for coordination of care between multidisciplinary teams, to include Continuous Quality Improvement to ensure quality of services are provided to offenders that address their physical and mental well-being.

(6) Annually and as needed, review/write/modify facility Standard Operating Procedures (SOPs).

(9) Jointly supervises health-trained personnel with Warden/designee at facilities that do not have 24/7 nursing services to ensure coordination of needed health services are available and provided to the offender population.

(10) Provides quarterly reports to Warden/designee on Health and Wellness services and performance improvements.

(g) The Director of Healthcare Administration provides support, to include but not limited to:

(1) Contract oversite,

(2) Budget,

(3) Procurement of all supplies, and equipment,

(4) Telehealth,

(5) Clinical Informatics.

(h) Medical Services are provided under the direction of the Medical Director/Chief Medical Officer who maintains responsibility for the quality of medical services provided to offenders.

(1) Services are provided in accordance with a professionally identified, evidenced-based Clinical Decision Support Resource.

(2) Specialty care services are provided by contracted medical specialty providers either at on-site specialty medical clinics in the prison facility or at the community medical office for the specialty provider.

(i) The Director of Nursing (DON) is responsible for nursing services provided to the offender population. Nursing Services function as an integral part of multidisciplinary teams and participate in the planning, implementation and monitoring of safe, evidenced based health care. By providing patient assessment, medication administration, crisis intervention, treatments, education and patient advocacy, Nursing Services is committed to improving the overall health and well-being of the individuals we serve.

(j) The Director of Pharmacy is responsible for all pharmaceutical services provided by the Central Pharmacy, a centralized outpatient pharmacy and on-site pharmacies at Central

Prison Healthcare Complex (CPHC) and North Carolina Correctional Institution for Women (NCCIW).

(k) The Chief of Psychiatry maintains responsibility for the quality of psychiatric services provided to offenders.

(l) Quality Assurance/Risk Management (QA/RM) is under the direction and responsibility of the Director of Quality Assurance. QA/RM functions as an integral component of Health and Wellness, DOP and NCDPS through the commitment to the provision of quality patient care and staff, and offender safety.

(1) Services are provided to:

(A) Ensure our healthcare system, policies, and practices adhere to an applicable and acceptable standard of care;

(B) Reduce the impact of negative events within Health and Wellness, DOP and NCDPS;

(C) Maximize opportunities for continuous quality improvement in staff performance and health and wellness services;

(D) Focus on clinical and administrative reports;

(E) Establish processes that:

(i) Identify, monitor, assess, mitigate, prevent risk of harm and liability to patients, staff and the agency.

12/22/20
Todd E. Ishee Date
Commissioner of Prisons